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ABSTRACT

Described and analyzed are procedures used in 38 Child Service Demonstration Projects throughout the U.S. for screening and identifying learning disabled children (LD). It is emphasized that the purpose of the project was to report viable alternatives for screening and identifying LD children rather than to recommend one particular model or screening test as the best. Information given on each of the 38 projects includes the delivery system for intervention (such as an LD resource room), the initial entry system utilized (such as teacher referral), and the personnel involved in decision-making (such as parents and psychologists). Flow charts provided depict the information gathering, information transmittal, decision-making and administrative procedures used in determining a child's eligibility for LD intervention. Among findings reported are: that the resource room is the most prevalent delivery system for LD children in public schools; that almost 80 percent of the projects use teacher referrals to identify potential LD children; and that emotional disturbance is the condition most likely to be specifically invoked as an exclusion criterion. Appended is the interview form used to gather data on projects. (LS)

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SCREENING AND IDENTIFICATION PROCEDURES IN THE CHILD SERVICE DEMONSTRATION PROGRAMS

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We also wish to thank our colleagues at the LTI-LD, faculty of the Department of Special Education at the University of Arizona, and other professional colleagues who contributed thoughts for our consideration as we evolved the study. Dr. Gerald Senf and Mrs. Cathy Crafts were especially helpful in the design of the study and the conduct of the interviews, respectively. Pamela Tyree, Nancy Spence, Diane Simrin, and Fran Record spent many hours typing manuscripts, tables, and charts. Their untiring efforts are here recognized and appreciated.

TABLE OF CONTENTS

Acknowledgements	i
Table of Contents	ii
List of Tables	iii
List of Figures	iv
Introduction.....	1
Purposes and Premises	1
Procedures	3
Report of Findings	4
Delivery Systems for Intervention	5
Initial Entry Systems	7
Types of Decisions	9
Format and Conventions Used in Flow Charts	a
Figural Conventions	b
Verbal Conventions	c
Other Conventions	c
Notations for Each Flow Chart	e
Appendix A -- Interview Schedule	f
Flow Charts and Notations	A-1

LIST OF TABLES

<u>Table</u>		<u>Page</u>
1	Delivery of Services Systems	5
2	Delivery Systems Utilized in CSDPs Surveyed (N=38)	6
3	Numbers and Percentages of the 38 Projects Which Utilized Each Delivery System (Singly or in Combination)	6
4	Initial Entry Systems Utilized by CSDPs for Screening of Potential LD Children	8
5	Key for Eligibility Decisions Needed in Determining Whether a Child Qualifies as Learning Disabled	10
6	Key for Letter Notations According to the Parameters for Inclusion Decisions	11
7	Conditions Which Specifically Excluded a Child from Consideration as a Learning Disabled Child by CSDPs	13
8	Numbers of Times Each Type of Inclusion Decision was Used as a Criterion for Determining Eligibility as a Learning Disability by CSDPs	14
9	Numbers of Times and Percentages Each Type of Inclusion Decision was Used as a Criterion for Determining Eligibility as a Learning Disability by CSDPs	15
10	Discrepancy Decisions vs. Deficit Decisions	15

LIST OF FIGURES

<u>Figure</u>		<u>Page</u>
1	Major Stages of Screening and Identification Systems	4

INTRODUCTION

As part of the overall research effort by the LTI-LD, we engaged in an analysis of the screening and identification processes utilized in the various Child Service Demonstration Projects (CSDPs) throughout the United States. These projects had been in existence as model programs in 43 states for periods ranging from one to three years under Title VI-G funding. In many instances these projects were built upon efforts of several years prior to the Title VI-G. Thus, we felt that the processes utilized by the CSDPs for screening and identification of children were probably representative of the array of best efforts in such activities throughout the country at the time of the study (October 1973-June 1974).

PURPOSES AND PREMISES

Our primary purpose in this investigation was to create a better understanding of the viable alternatives for screening and identifying children in determining whether they are eligible for delivery of services as children with SLD. Please note some underlying premises of our study.

1) We did not assume that there is only one best model for screening and identification of SLD children. Rather, there are many models or systems for carrying out this process. And, we begin with the assumption that a number of these systems, or their modifications, may be equally viable, depending upon other variables. In our study we hoped to lay out, then, alternative systems for screening and identification. We also intended to lay out the effects of other variables in determining which model would be the optimum choice among all alternatives in a given situation. Variables might include: age or grade, type of delivery system, size of school district, size of geographic boundaries, availability of various types of professional personnel, availability of supportive services for L.D. and other handicapping conditions, length of time over which L.D. services have been available in the system, etc.

Because the funding of this project was terminated, time did not allow us to accomplish this latter goal. Rather, our report here consists primarily of a description of the screening and identification systems, together with some conclusions and analysis of the decision-making process.

Since we assumed that there are a number of viable alternatives to the screening and identification process, our research activity centered around three objectives:

- a) Identifying the variety of systems used in screening and identification by the CSDPs;
- b) Creating a model for classifying or categorizing the decision-making process utilized in the screening and identification systems; and
- c) Suggesting what variables are of importance in deciding which system to select at a given locale.

2) Another assumption was that we should not focus on a specific test, battery of tests, or screening index in our analysis of screening and identification. We did not wish to end our study by recommending a single test to be used by all in screening. Again, our aim was to lay out valid alternatives as far as the use of screening instruments is concerned.

Consequently, our study focused on the analysis of the decision-making process for screening and identification of SLD children. Questions of importance here were as follows:

- a) What types of children were the screening and identification process attempting to uncover? And what delivery system was the screening aimed at?
- b) In what person (or persons) was the decision making centered? (e.g. Was it a psychologist-oriented system; an L.D. Specialist-oriented system; a team-oriented system, etc?)
- c) What were the stages of the decision-making process, and what was the sequence of these stages? (e.g. When is the exclusion of non-SLD handicapping categories, such as MR, ED, or sensory deficits accomplished?)
- d) What provisions were made within each system to bring together adequate information to make the necessary decisions at each stage? Here we were concerned with all forms of information, such as cumulative records, testing, observations, effects of previous teaching, interviews--whatever information was utilized by each system.

Regarding the gathering of information, we were concerned about several questions: Was the information adequate to make the decision required? What were the criteria at a given stage for a given decision? Who made the decision at a given stage? What competencies are needed by a person to make that decision? Was information gathering and/or decision making redundant throughout the system? Were there checks and balances within the system to avoid premature or unwarranted decisions?

In this final report, we do not make definitive conclusions or evaluative statements regarding the above questions for each specific screening and identification system. Rather, we leave it to the reader to use these questions as a guideline in evaluating the systems as they are described in flow chart form in the following sections of this report.

Furthermore, we would suggest that these questions (and others we have posed) can be used as part of a systems analysis approach by any professional who wishes to evaluate an operational screening and identification system, or a system that he may contemplate utilizing.

PROCEDURES

The essential aspect of this report consists of a description of 38 CSDP Screening and Identification systems, presented in flow chart forms, together with explanatory notations. Although there were 43 Child Service Demonstration Projects funded under Title VI-G at the time of our study, data were not collected from seven projects. The reasons included a) screening system not yet established in a new project; b) screening system not utilized by the project; c) lack of success in arranging an interview. There were 38 systems, however, in our analysis because two of the projects each utilized two different screening and identification systems. Consequently two separate and complete interviews were completed within those projects. (See appendix A).

All data were gathered by means of a semi-structured interview schedule that could be considered as a focused interview. These interviews were conducted either by phone or direct face-to-face interview by the co-authors of this study and one additional trained member of the research staff. In most instances, the informant was either the Director, or someone designated by him/her as the most knowledgeable person in the project concerning the subject of the system used for screening and identifying children as being eligible for service as SLD in the particular delivery system for that project. All interviews were tape recorded and subsequently transcribed for analysis. The flow charts were then constructed by the co-authors of this report, based on the interview transcriptions, together with written materials and diagrams provided by CSDP personnel. Whenever it was deemed necessary the investigators sought additional clarification from the project staff.

In constructing and compiling the flow charts to depict the screening and identification systems, an attempt was made to standardize terminology for purposes of cross-comparisons. Please note that any ambiguities, misrepresentations, or inaccuracies in the depictions and descriptions of these systems rest solely on the decisions made by the co-authors. Due to time constraints produced by the sudden and unexpected termination of funds for this research program, we were unable to verify all of our decisions with the CSDP personnel. We sincerely hope that we have not seriously misrepresented their processes in our designations. However, we can assure the

reader that we had ample information and labored many hours to provide as true a picture as we could humanly draw at this time. It must be understood, however, that some errors probably do exist in our interpretations of what actually occurred. We remain convinced, however, that the critical aspects of what we report in the ensuing pages are founded in fact.

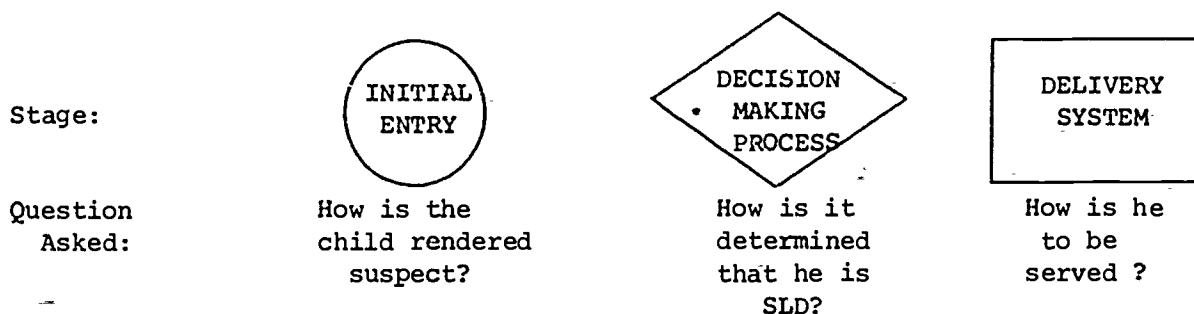
REPORT OF FINDINGS

The remainder of this report consists of our findings concerning the (CSDP) Screening and Identification Systems. There are basically three aspects of these systems in the order in which they occur chronologically for the child.

- (1) The Initial Entry
- (2) The Decision-Making Process
- (3) The Delivery System

FIGURE 1

MAJOR STAGES OF SCREENING AND IDENTIFICATION SYSTEMS



A summary of the delivery systems used in the CSDPs is found in Tables 1, 2, and 3. A summary of the initial entry systems utilized is in Table 4. Subsequently, Tables 5, 6, 7, 8, 9, and 10 summarize the decision-making processes as we have analyzed them. Following is a discussion of each of these stages of screening and identification as they were accomplished by the 38 CSDPs surveyed. The final section describes the precise flow charts for each project.

Delivery Systems for Intervention

Delivery Systems were designated according to the role of the L D Specialist(s), as represented in the following continuum in Table 1. The continuum represents the degree of direct intervention by the L D Specialist(s) from greatest to least amount.

TABLE 1

DELIVERY OF SERVICES SYSTEMS (Continuum based on degree of direct intervention by L D Specialist)

<u>Delivery System</u>	<u>Intervention</u>
L D Self-Contained:	L D Specialist provides <u>total</u> educational service;
L D Resource Room: (Service in special room)	L D Specialist provides <u>partial</u> service;
L D Specialist Mainstreaming: (Service in regular classroom)	
L D Consultative:	L D Specialist provides <u>prescriptive</u> service to the actual teacher agent.

A summary of the delivery systems, or combined delivery systems utilized in the 38 projects surveyed is represented in Tables 2 and 3 on the following page.

TABLE 2

DELIVERY SYSTEMS UTILIZED IN CSDPs SURVEYED (N=38)

<u>Single Systems</u>	
Self-Contained	1
Resource Room	14
Mainstreaming (Specialist)	2
Consultative	5
	<hr/>
Single System	22
 <u>Combined Systems</u>	
Self-Contained and Resource	3
Self-Contained and Consultative	2
Resource Room and Consultative	7
Self-Contained, Resource Room and Consultative	4
	<hr/>
Combined Systems	16

TABLE 3

NUMBERS AND PERCENTAGES OF THE 38 PROJECTS WHICH UTILIZED
EACH DELIVERY SYSTEM (SINGLY OR IN COMBINATION)

<u>Delivery System</u>	<u>N</u>	<u>%</u>
Self-Contained	10	26.3
Resource Room	28	73.7
Mainstreaming (Specialist)	2	5.3
Consultative	18	47.4

Several comments are in order in regard to Tables 2 and 3.

Of the systems reviewed, nearly sixty percent used only one type of delivery system as an option. Whether this is representative of the total school systems within which the CSDPs operated, we cannot be certain. However, it is our feeling that whenever possible, multiple options should be available so that maximally efficient and effective placement is possible for every child needing service.

It is also interesting to note that whenever a single model for delivery of service was chosen, the predominant choice was the Resource Room. The Resource Room delivery system stands today as the most prevalent option open to an LD child in public schools in this country. Nearly three-fourths of all programs had this as an option (See Table 3). Next in popularity is the consultative, or prescriptive model, wherein the LD-Specialist serves primarily as a diagnostician and prescriber of techniques to the regular teacher.

In regard to Self-Contained delivery systems it should be noted that only one of these occurred as a lone option. Self-contained LD rooms tended to occur as one option in systems offering more than one choice. Furthermore, in two instances, the self-contained class was a "transitional" classroom and probably did not contain SLD children solely.

Initial Entry Systems

Initial entry into the screening and identification system is the method by which a child first becomes designated as potentially qualifying for intervention as a learning disabled (LD) child. There are essentially two basic methods of initial entry:

Referral: In this instance a specified person raises the initial question of eligibility regarding the child. This person is usually the teacher. However, in many systems a parent, physician, or other agent may also serve as the person initiating the referral process. In most circumstances the referral is routed through the teacher. Therefore, in general the "referral method" may be considered as "teacher referral."

Mass Screening: In this instance all children from an eligible pool are screened for evidence of learning disability, usually by means of a particular group test or battery of group tests. Children usually qualify as potential LD under such a procedure based on a cut-off score on the particular test or tests.

In other instances, screening consists of a search of already available data, such as cumulative records, or testing done for other purposes.

Although another type of mass screening is possible, that method was never used in any of the projects analyzed. That system is mass teacher rating. Under this type of procedure, the regular teacher would be required to rate all of her students on a behavior rating scale. Children would then be designated as potential LD depending upon the results of these ratings. Although many systems utilized teacher rating scales or behavior checklists, none were accomplished full scale; they only rated children who were referred as possible LD.

Following is a summary of the number of projects using the various Initial Entry Systems (Table 4).

TABLE 4

INITIAL ENTRY SYSTEMS UTILIZED BY CSDPs
FOR SCREENING OF POTENTIAL LD CHILDREN

<u>Initial Entry System</u>	<u>N</u>
Teacher Referral	30
Mass Screening	8
Mass Rating	0
Total	<u>38</u>

The overwhelming choice of the CSDPs was to use teacher referral (almost 80%). Therefore, a keystone to the entire process of identification of children with LD is the regular teacher's competency to refer. It is well worth future research effort to test the efficiency of this link in the system. Our impressions from this study and previous experiences indicate that teachers are relatively efficient. The "hit rate" for children who are actually referred is generally high, and can be identified readily for any particular system. What is less well known is the proportion of false negatives (children with LD who are not referred by the teacher). This should be studied carefully in any system. We recommend highly that research into variables affecting teacher competence in this realm be encouraged.

Types of Decisions

The decision-making process consists of two types of decisions: (A) those decisions which raise questions about the child's eligibility as an LD child, i.e., as a child who will be eligible to receive intervention as an LD child; and (B) those decisions which do not bear directly on the determination of the child's eligibility of qualification as an LD child, but which may or may not allow him to be enrolled in the intervention service(s), or may determine which of alternative services he will be assigned to.

Eligibility Decisions. These types of decisions are of three types, as seen in Table 5 on the following page. The letter designations are used as notations in the flow charts to indicate when such decisions are made.

The first type of eligibility decision is that which coincides with the Initial Entry phase of the screening and identification system. That is designated as the "Suspect Decision" (S) in Table 5. It simply asks the question as to whether any person (or any test score) considers the child suspect of being learning disabled.

The second type of eligibility decision is that which determines whether the child should be "excluded" from consideration as an LD. Decisions C and I in Table 5 are "Exclusion Decisions." They may be considered as answering the question "Is there present any other condition which could be considered as a primary cause of learning failure?" Specific conditions are listed separately, because it is of special significance and is essentially universal in application of the definition for specific learning disability.

Decisions a, aI, p, and pI in Table 5 are classified as "Inclusion Decisions." These are decisions which designate specifically whether a child qualifies as having a specific disability in learning. The Inclusion Decisions consist essentially of all possible combinations of two parameters viz, deficit vs discrepancy; and academic learning vs basic psychological processes. Thus, a and p represent "deficit" statements, a being deficit(s) in academic learning and p being deficit(s) in basic psychological processes. A deficit is defined as a "low" in the behavior considered. This is an absolute value, not relative to any other intra-individual functioning. It is usually relative to a group norm or a criterion reference. Thus, it is an inter-individual difference.

Likewise, aI and pI represent two types of "discrepancy" conditions: aI represents a discrepancy between academic achievement and intelligence (potential); whereas pI is a condition denoting a discrepancy between a basic psychological process and intelligence (potential). Thus, the discrepancy conditions represent "intra-individual" differences with measured intelligence usually as the reference mark to compare against other more specific abilities. Table 6 depicts the Inclusion Decision parameters.

TABLE 5

KEY FOR ELIGIBILITY DECISIONS NEEDED IN DETERMINING WHETHER
A CHILD QUALIFIES AS LEARNING DISABLED

SUSPECT DECISION	EXCLUSION DECISIONS	INCLUSION DECISIONS
S: Is he suspected of having I.D.?	<p>C: Is there present any other condition which could be considered as a primary cause of learning failure?</p> <p>Ch: hearing disorder;</p> <p>Cv: visual disorder;</p> <p>Ce: emotional disturbance;</p> <p>Cd: environmental disadvantage;</p> <p>Cm: motor (neurological) handicap;</p> <p>Co: other.</p> <p>I: Is his intelligence below normal?</p>	<p>a: Is his academic achievement below normal? i.e., is there a <u>deficit</u> in reading, writing, spelling, arithmetic?</p> <p>aI: Is there a <u>discrepancy</u> between his academic achievement and his intelligence (potential)?</p> <p>p: Is there a <u>deficit</u> in any basic psychological process? (e.g. perception, memory, receptive language, expressive language, motor--i.e. non-academic functions).</p> <p>pI: Is there a <u>discrepancy</u> in any basic psychological process, relative to intelligence (potential)?</p>

TABLE 6

KEY FOR LETTER NOTATIONS ACCORDING TO THE
PARAMETERS FOR INCLUSION DECISIONS

TYPE OF LEARNING	TYPE OF DISABILITY	
	Deficit	Discrepancy
Academic	<u>a</u>	<u>aI</u>
Psychological Processes	<u>p</u>	<u>pI</u>

In each of the Flow Charts presented below, the eligibility decisions are noted. When a diamond, or decision-making point on the chart is accompanied by a broken line extending horizontally, it represents an eligibility decision. The letters on that broken line (e.g. S, I, C, aI, a, pI, p) indicate, according to the key noted above, which type(s) of eligibility decisions are made at that juncture in the system. A C, rather than Ch, or Ce, etc., means that undesignated conditions for exclusion are checked at that point.

Whenever a diamond is not accompanied by a broken horizontal line, we have considered that as a constraining decision, discussed below.

Constraining Decisions. Following are examples of constraining decisions, that is decisions which do not bear directly on the determination of the child's eligibility or qualification as an LD child, but which may or may not allow him to be enrolled in the intervention service, or may determine which of alternative services he will be assigned to.

Does the child meet the State guidelines?

Can the system be by-passed (parent pressure, etc.)?

Does the parent give permission to test; to place?

Is there appropriate service delivery system in his school?

Can he be transported to school where system is available?

Can he be served now, i.e., is there a waiting list?

Will we put him in the delivery system, even though he does not qualify precisely?

Are other alternate delivery systems available?

It is well to look at any system to determine whether constraining decisions are acting for or against the child's ultimate good, or whether constraining decisions are unduly burdensome for the efficiency and effectiveness of the system. This may be particularly true in cases of too many layers of administration.

Discussion of the Decision-Making Processes Used in Determining Eligibility for LD Services. The following is concerned with the types of decision-making processes utilized by the CSDPs. The discussion will first consider the exclusion decisions, then the inclusion decisions.

Exclusion Decisions. Referring to Table 5, we see that there were three types of decisions made: (a) Suspect decisions, (b) Exclusion decisions, and (c) Inclusion Decisions. All projects utilized the Suspect Decision, and these are represented by our discussion of the Initial Entry Systems.

The initial entry system determined how a child was rendered suspect of LD. Then a series of decisions was made to determine whether he had other conditions which would exclude him from consideration as an LD child.

One of the conditions was evidence of "normal" intelligence. Of the 38 CSDPs, 31 gave distinct evidence of designating normal intelligence before certifying that the child could be classified as LD. The exceptions were projects which had varying reasons for not expressing a clear-cut determination of normalcy of intelligence. For example, some Pre-School or Kindergarten projects followed a developmental approach and intervened with all children showing deviations, regardless of level of overall ability; other projects stressed the need to be concerned with cultural and/or environmental factors which might influence the designation of "intelligence;" and in one case we are simply not certain that a decision of this nature was made.

It is safe to say, however, that most projects, faced with the task of certifying children as eligible for LD services, chose to determine overall level of ability (or potential) by some means. The methods they used and the criteria applied to make that decision were so varied that they defy generalization. No attempt, therefore, will be made to do so in this report.

The other conditions which projects attempted to apply as exclusion criteria also varied. In fact it was often difficult for us to determine whether they applied certain criteria or not. Thirty-three of the 38 CSDPs (86.8%) indicated the application of some exclusion criteria, other than general ability. The following table (Table 7) summarizes the number of projects which specifically stated certain exclusions in their descriptions of the decision-making process:

TABLE 7

CONDITIONS WHICH SPECIFICALLY EXCLUDED A CHILD
FROM CONSIDERATION AS A LEARNING DISABLED CHILD BY CSDPs

<u>Condition</u>	<u>N</u>	<u>Percent</u>
Emotional Disturbance	15	39.5
Visual Handicap	11	28.9
Hearing Handicap	11	28.9
Motor Handicap	6	15.8
Disadvantage	2	5.3
General (used, but unspecified)	14	36.8
None (or Do not know)	5	13.2

Thus, although a very high percentage of projects used certain conditions as exclusion criteria, no more than 40% gave evidence of using any specific item. About one-third of the projects gave general indication of exclusion criteria, but we could not discern which ones they always applied. Emotional disturbance was the most likely to be specifically invoked as an exclusion criterion (39.5%), with visual and hearing handicaps next most frequent (28.9%). Only 15.8% specifically noted motor (or neurological) factors; and only 5.3% considered disadvantage as an exclusion criterion.

Thus, there is considerable variance throughout the United States in regard to whether various exclusion criteria are applied before a child can be considered as having a learning disability. The variations in criteria are so prevalent that the populations of children being served by CSDPs are apparently very heterogeneous. We did not collect data precisely to this point, but the methods of selection are so variant that they almost dictate such a result.

Inclusion Decisions. The types of inclusion decisions also varied across the projects so that few clear generalizations can be made. Perhaps the only safe generalization is that there is little consistency regarding how children are operationally defined as LD. The decision-making processes as we analyzed them were so varied that virtually all possible choices or combinations of choices were used.

There are four possible ways a child could qualify as LD, according to various inclusion decisions:

- a - academic achievement deficit
- aI - academic achievement discrepancy (relative to potential)
- p - psychological process deficit
- pI - psychological process discrepancy (relative to potential)

Any one or any combination of these criteria could be used in decision making. Table 8 summarizes the number of times each was used.

TABLE 8

NUMBERS OF TIMES EACH TYPE OF INCLUSION DECISION
WAS USED AS A CRITERION FOR DETERMINING ELIGIBILITY AS A
LEARNING DISABILITY BY CSDPs

<u>One Criterion</u>	<u>Two Criteria</u>	<u>Other Criteria</u>
p: 4	aI, pI: 10	aI, pI, p: 1
a: 1	a, p: 2	aI, pI, a, p: 13
aI: 3	aI, p: 2	No criteria: 1
pI: 0	pI, a: 1	
	a, aI: 0	
	p, pI: 0	
<hr/> 8	<hr/> 15	<hr/> 15

Thus, very few (8) CSDPs relied on only one criterion, and there was little consensus if only one was selected. If a discrepancy criterion was chosen, however, the tendency was toward academic discrepancy. But, when deficit was the criterion, the choice was for psychological processes. This trend is maintained, but only slightly, when we combine all criteria used singularly, or in combination, as in Table 9.

TABLE 9

NUMBERS OF TIMES AND PERCENTAGES EACH TYPE OF INCLUSION DECISION WAS USED AS A CRITERION FOR DETERMINING ELIGIBILITY AS A LEARNING DISABILITY BY CSDPs (COMBINED FIGURES)

<u>Key</u>	<u>Type of Decision</u>	<u>N</u>	<u>Percent</u>
(aI)	academic achievement discrepancy :	29	76.3
(pI)	psychological processes discrepancy :	25	65.8
(p)	psychological processes deficit :	22	57.9
(a)	academic achievement deficit :	17	44.7

Or, we could view the decision-making in regard to the preference for discrepancy vs deficit as the keystone. Table 10 shows how many decisions were made, according to those parameters:

TABLE 10

DISCREPANCY DECISIONS VS DEFICIT DECISIONS

	<u>N</u>	<u>Percent</u>
Discrepancy-only decisions	13	34.2
Deficit-only decisions	7	18.4
Deficit and/or discrepancy decisions	17	44.8
No decision	<u>1</u>	<u>2.6</u>
	38	100.0

Approximately one half (20/38) selected an exclusion decision-making process (Table 10). That is, the child could be classified as a learning disability only if he was determined to have a discrepancy of some type in some of the projects; whereas other projects only considered him to have an LD if he demonstrated a deficit of some type.

Among the projects which restricted the eligibility, the overwhelming trend was to accept evidence of discrepancies only, rather than deficit only (See Table 10). But nearly 45 percent of the projects (17) allowed the child to qualify as LD if he had either a deficit or a discrepancy. One project never formally made a decision, but placement was essentially on an overall deficit in performance.

Thus, the question might be raised as to whether children in the U.S. are classified as LD primarily because of deficit performances or intra-individual discrepancies (usually between a performance and a "potential"). The analysis shown in Table 10 indicates that each type of criterion is used widely, with nearly half of the projects accepting either deficit or discrepancy. But, when a choice was made, the trend was 2 to 1 for selecting discrepancy as the criteria. This trend was also seen in Table 9. Academic discrepancy was utilized 29 times as opposed to 17 instances where academic deficit was allowed. Discrepancy was also the preferred criterion when psychological processes were used as the gauge, but only by a narrow margin of 25 to 22 (Table 9). Thus, it can be said that discrepancy criteria and deficit criteria are both utilized widely, throughout the United States, but when a choice of these two is made, the result is predominantly to select discrepancies, or intra-individual variability.

We might also look at the selected criteria for inclusion from the parameter of academic achievement vs performance in psychological processes. There is virtually no agreement among LD CSDPs concerning which type of criterion to use. As seen in Table 9 there were 47 single or combined instances where psychological processes were the criteria, and 46 comparable instances for academic achievement. Looking at the figures in Table 8, we see that 4 projects used academic-only criteria, and 4 CSDPs used psychological processes criteria only; but 30 used each as qualifiers by some combination. In fact, in every instance where more than one criterion was used, the selection included at least one academic and one process factor.

Another interesting trend may be noted in reference to the choices made when only one criterion was allowed (Table 8). Although the numbers are small, the choices were distinct and perhaps tell us something about the interaction between the discrepancy-deficit parameter and the academics-psychological processes parameter. In Table 8 it can be seen that whenever a discrepancy was the sole criterion allowed to qualify as LD, the choice was 3 to 0, with academic discrepancy being the qualifier. In contrast, when deficit was the lone selector the criterion factor was psychological

process by a 4 to 1 margin. Or, whenever academic criteria were used, the choice was 3 to 1 for accepting discrepancy; but when psychological processes were the criteria, the choice was 4 to 0 in favor of deficit. Thus, regardless of the parameter from which we view the interaction between behaviors and the indices of difficulty, there is a trend to consider academic behavior deviant when it is discrepant; but psychological processing deviant if it is deficient in comparison with other individuals, regardless of overall ability.

It would appear, then, that we are inconsistent of our views regarding the ways in which intra-individual differences (discrepancies) and inter-individual differences (deficits) are interpreted as designating a disability. This inconsistency, together with our varied criteria for decision-making regarding eligibility for LD services, may explain much of the confusion in this country regarding placement and intervention for LD children. It may be the prime reason that we have an extremely heterogeneous population of children throughout the United States being served under the single rubric: Learning Disabilities.

To summarize the operationalizing of the definition of learning disabilities as manifested by the decision-making processes of 38 Child Service Demonstration Projects, we conclude the following:

- (1) There is wide variance in the criteria used throughout the U.S. for designating children as LD, i.e., for certifying them as eligible for LD services.
- (2) Although most CSDPs considered below normal intelligence as an excluding criterion for designation as LD, the methods used to make such determinations were varied.
- (3) Other excluding criteria were also varied, but most projects utilized some criteria other than intelligence, with emotional disturbance, hearing, visual, and motor handicaps as the most prominently considered exclusions.
- (4) Inclusion criterion varied in regard to several parameters:
 - (a) Although both discrepancy and deficit criteria are invoked in various decision-making systems, the preference is toward the discrepancy model, expressing intra-individual variability as the index of learning disability;
 - (b) When viewing the preference for academic deviance, opposed to psychological processes, as the primary indication of learning disability, there is virtually no agreement among CSDPs. One dimension is just as likely to be chosen as the other.
 - (c) However, if we look at the interaction between the deficit-discrepancy parameter and the academics-process parameter, we find that academics is usually considered to be a problem if it is discrepant, but processing is thought of as a problem when it is deficient.

All of these conclusions and generalizations gleaned from our analysis of the decision-making processes of the 38 Child Service Demonstration Projects make it evident why the LD population in the United States today is so heterogeneous. Only if each project or system which wishes to select LD children will perform the type of systems analysis that is reported herein will they truly know what decisions they are making. Then they can decide intelligently whether this meets with their objectives and with their delivery of service system needs.

We encourage all who need to analyze their selection process to review the remainder of this report in detail. Each of the systems presented in the next section in flow-chart form represents a system that has been put into action. Each system has advantages and disadvantages. The reader is encouraged to make his own analysis of such for each project. We have provided the flow charts and some notations so that each operational system can be understood. After reviewing the 38 CSDP Screening and Identification Systems described below, we urge you to create a similar analysis for your own current system, or proposed system. You will be surprised at how it will lay open for you the strengths, weaknesses, and specific gaps in any system. If you follow such an evaluation procedure, it can only lead to improvement in all systems for designating children as LD.

FORMAT AND CONVENTIONS USED IN FLOW CHARTS

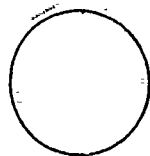
The flow charts presented in the final section are intended to depict the information gathering, information transmittal, decision-making and administrative procedures used in determining whether a child from a large pool of children may be designated as eligible to receive a specified type of intervention for children with learning disabilities. They depict the screening and identification system only. They do not consider the intervention systems, except as an end of the screening and identification process.

The charts have been created in such a manner as to represent the major flow of activity for a child from a point of initial placement (usually the regular classroom) to the final designation of eligibility for intervention (i.e., placement in a delivery system designated for LD children). Thus, a horizontal arrow to a circle represents the child "returning to START" in the system. If the child had only the alternative of returning to START or of being placed in the intervention system, the screening and identification system would classify as a "closed system."

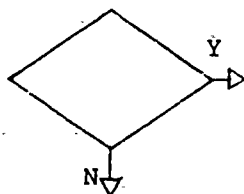
However, there are often instances where decision-making results in consideration of other placements or decisions which would take the child outside the system. A horizontal arrow leading to a rectangle indicates an instance where the child leaves this particular screening and identification system. If such instances occur, the system is an "open system."

We have not concerned ourselves with the nature of these referrals outside the LD identification system, nor with any specific re-entry procedures by which children may return to the system if referred out at any point.

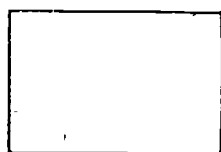
Figural Conventions



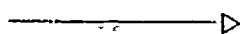
A circle is used to denote the starting point for each screening and identification system. In most instances this refers to the child's placement in a regular class. Exceptions are noted whenever they appear. Throughout the charting, whenever the child is disqualified as a candidate for learning disabilities intervention, an arrow to a circle indicates that he returns to (or remains in) his regular class placement.



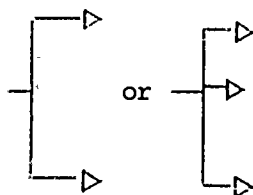
A diamond is used to indicate decision points in the system. The symbols "Y" and "N" are used to represent "Yes" and "No," respectively, where the question asked can be answered accordingly. At other points where multiple solutions may result, arrows simply indicate possible solutions.



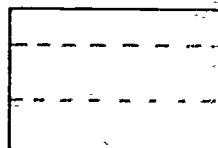
A rectangle is used to indicate information gathering, information transmittal, or other non-decision-making stages in the system.



A single arrow leading from a symbol indicates that all children would follow this path.



More than one arrow leading from a symbol indicates that children may take any one of the alternate routes.



Whenever more than one event occurs simultaneously, the events are listed together under one rectangle, but the activities are separated by dotted lines.

Verbal Conventions

Personnel. In order to standardize the representations of activities of Learning Disabilities Specialists, we designated them according to their primary role in the direct intervention of the child, as follows:

- L D Teacher: An LD Specialist who provided direct remediation in the intervention system;
- L D Consultant: An LD Specialist who provided consultation or prescriptive services to the teacher-agent;
- L D Diagnostician: An LD Specialist who provided only screening or diagnostic services to the child, but did not participate in direct intervention, unless for diagnostic purposes;
- L D Coordinator: An LD Specialist who performed administrative and/or decision-making functions, but no direct teaching, consultation, or diagnostic services.

Conversely noted non - L D Specialists included the following:

- Teacher: The "regular" teacher, unless otherwise noted;
- Coordinator: Non - LD Specialist who provided administrative and/or decision-making functions, but no direct teaching, consultation or diagnostic services;
- Director of Special Education: Administrative person responsible for entire special education systems. (May or may not have been LD Specialist by training, but functioned in the role for total system; not LD alone.);
- Other Agents: Specifically designated in self-explanatory terms (e.g. social worker, guidance counselor, school nurse, principal, reading teacher, speech and/or language therapist, psychologist, parent).

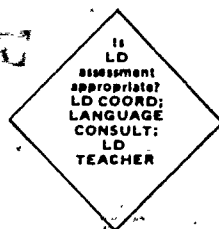
Other Conventions

In describing decision-making points within the diamond-shaped figures, we have followed these conventions:

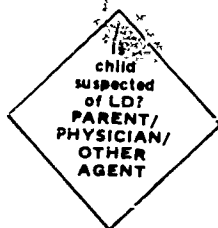
- (1) The decision is stated in question form;
- (2) The agent(s) making the decision is (are) designated in capital letters; e.g.



- (3) If more than one agent is involved, they are separated by semi-colons;



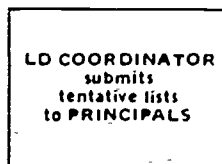
- (4) If either one or another agent is involved, they are separated by slashes;



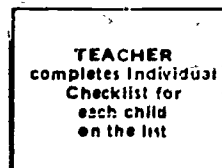
In the latter instance, where there is an either-or circumstance, a notation is made as to how it is determined which person will actually make the decision.

In describing non-decision-making events within the rectangular-shaped figures, we have followed these conventions:

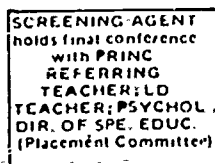
- (1) Statement of events described is in active voice;
- (2) All agents involved in these events are designated in capital letters; e.g.



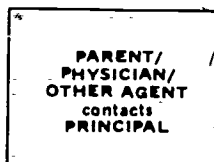
OR



- (3) If more than one agent is involved, they are separated by semi-colons;



- (4) If either one agent or another agent is involved, they are separated by slashes;



In the latter instance, where there is an either-or circumstance, a notation is made as to how it is determined which person will actually participate in the event.

Notations for Each Flow Chart

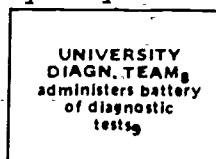
Before reading the flow charts, please note the following: In the notations section following each flow chart, we have listed I. GENERAL INFORMATION, II. SPECIAL NOTATION.

I. General information includes the following:

- 1) The Project Code Letter. Arbitrarily designated letter (s) to preserve the confidentiality of the information gathered in this study and the anonymity of each project.
- 2) The Delivery System for Intervention. These are stated according to the models listed above. Although the particular project may have given the delivery system a unique name, such as retrieval room, or learning center, we have standardized our terminology, according to our conception of how their actual delivery coincided with our definitions. Grade levels included in the system are noted in parenthesis.
- 3) The Method of Initial Entry (Referral and/or Mass Screening). In cases of referral we have listed the possible referral agents in parentheses with the listing of multiple referral agents in the rank order of most referrals. For Mass Screening we have indicated in parentheses the primary instrument(s) used.
- 4) Personnel Involved in Decision-Making. This notation includes a simple listing of all personnel involved in decision-making by type of decisions rendered, i.e., eligibility decisions (Does he qualify as LD?) or constraining decisions (decisions not dealing directly with that general question).

II. Special Notations are made where further information is available and would be helpful to the reader in attempting to understanding the system. For example, a battery of tests might be listed; an exception in the system might be noted, etc.

Special notations are keyed by footnoting in the charts.



In listings of tests or test batteries, those tests that are routine or required within the system are generally noted without parentheses; tests listed within parentheses are optional and determined by the agents listed in that event description unless otherwise noted.

Common Test abbreviations include:

Binet = Stanford Binet Intelligence Test
Bender = Bender-Gestalt
Benton = Benton Visual Retention Test
BESI = Basic Educational Skills Inventory
Boehm = Boehm Test of Basic Concepts
CAT = Children's Apperception Test
CMM = California Mental Maturity Tests
CPQ = Children's Personality Questionnaire
CTBS = California Test of Basic Skills
Detroit = Detroit Test of Learning Aptitude
Durrell = Durrell Analysis of Reading Difficulties
Fitzhugh = Fitzhugh Plus Placement Test
Frostig = Frostig Test of Visual Perception
Gates-McKillop = Gates-McKillop Reading Diagnostic Test
Gilmore = Gilmore Oral Reading Test
Goodenough = Goodenough-Harris Draw-a-Man Test
IRI = Informal Reading Inventory
ITBS = Iowa Test of Basic Skills
ITPA = Illinois Test of Psycholinguistic Abilities
Lincoln-Oseretsky = Lincoln-Oseretsky Motor Tests
Lorge-Thorndike = Lorge-Thorndike Intelligence Test
MAT = Metropolitan Achievement Test
PBRs = Pupil Behavior Rating Scale (Myklebust)
PDS = Predictive Dropout Study
PIAT = Peabody Individual Achievement Test
PMA = Primary Mental Abilities Test
PPVT = Peabody Picture Vocabulary Test
Purdue = Purdue Perceptual Motor Survey
PSLT = Picture Study Language Test
Rappaport = Rappaport Fine-Motor Skills Test
Silvaroli = Classroom Reading Inventory
SIT = Slosson Intelligence Test
Spache = Diagnostic Reading Scales
TAT = Thematic Apperception Test
VMI = Berry-Buktenica Test of Visual Motor Integration
Wepman = Wepman Test of Auditory Discrimination
WISC = Wechsler Intelligence Scale for Children
WRAT = Wide Range Achievement Test
Zaner-Bloser = Zaner-Bloser Handwriting Sample

APPENDIX A



THE UNIVERSITY OF ARIZONA

TUCSON, ARIZONA 85721

COLLEGE OF EDUCATION

Department of Special Education

Leadership Training Institute

48 N. Tucson Blvd.

Tucson, Arizona 85716

The Leadership Training Institute in Learning Disabilities is compiling a summary of procedures that are being used to select children for Title VI-G projects. This is not being done to evaluate individual projects or their selection (screening) procedures, nor is the information being gathered for BEH as part of its evaluation procedures.

The data gathering is planned as part of the LTI research program aimed at better understanding the alternative methods for identifying children with learning disabilities. The 43 Title VI-G projects in operation this year represent a wide variety of workable selection procedures. While our research is principally at the descriptive level, attempts will be made to classify these identification procedures. In collecting data from each project regarding its selection system, we will be able to disseminate a useful summary of the various procedures to each CSDP and to the field.

We can assure you that information received will be coded and grouped so that no direct comparisons will be made among projects; in fact, no report of this research will identify a project by state or locale. All participating projects will receive a copy of the findings of this research, so that they will be the first to share in the benefits of this communication.

We plan to gather the information by phone interview during the month of January. To make most efficient use of the interview time, we will need to talk to the person(s) most familiar with the total pupil selection process (i.e., the methods used to choose children to be served by the program) in the initial core project. Would you please return the enclosed postcard identifying for us the most knowledgeable person(s) to contact? If we do not hear from you within a week, we will assume that you are the person to contact. In either case, we will call to arrange an appointment for the phone interview. Our estimate is that the interview will take a half to three quarters of an hour.

Thank you for your assistance.

Sincerely,

Harold J. McGrady, Ph.D.
Program Associate

INTERVIEW SCHEDULE: SELECTION PROCEDURES

State: _____ Date: _____

Project Year (circle) I II III Interviewer (circle) C L H J

Director: _____

Interviewee: _____ Position: _____

It would be helpful if we could tape this interview, since we can move through the questions faster, and we also get a better record. We will, of course, code the transcript so that you and the project can remain anonymous. So unless you have any objections . . . ((turn on recorder)) then we've agreed to tape this interview.

opening questions

Keep in mind that all questions in the interview are addressed to the core project rather than any of its replications.

- 1.1 What kind of children are you looking for in this project? We'd like a picture of the children for whom the services are designed.

- 1.2 ((If flow chart is unclear, go over each step and clarify what you don't understand.))

((If no flow chart is available to you now, ask person to briefly describe the complete process by which the children are identified and selected to receive project remedial services. Emphasize steps from beginning to end. Construct a flow chart from this description.))

general background

- 1.3 Who originally decided what process should be followed to identify children for the project? That is, who designed the procedure now in use?

NAME: _____ Position: _____

1.4 Why did you decide to use these particular procedures? _____

1.5 Were there any other factors that influenced your decision? _____

mechanical process

2.1 Which of these procedures are used as a first step in identifying children who should receive remedial services through the program? ((use checkmark))

_____ teacher referral of children with problem

_____ mass teacher rating of all children

_____ mass testing of all children

_____ other (specify) _____

If only one is checked, go to 2.2

If more than one is checked, go to 2.4

2.2 Are there any other ways that a child can enter the initial screening process?

_____ yes (go to 2.3)

_____ no (go to 2.6)

2.3 What other initial steps might be taken? ((add to 2.1, using an X, and go to 2.4)

2.4 What determines which procedure is used? _____

2.5 Who is responsible for this decision? _____

We want to spend some time talking about your teacher inservice efforts. Again, if there are any forms available for this process, we would like copies.

2.6 Were the teachers provided with any information or orientation about the nature of LD or the types of children to be selected?

_____ yes (go to 2.8)

_____ no (go to 2.7)

2.7 Does this mean teachers were not informed about the project at all?

_____ not informed (go to 3.12 if teacher referral; 6.13 if mass rating; 8.19 if mass testing; 11.19 if other process)

_____ they were informed (revised opinion) (go to 2.8)

2.8 Did the orientation involve formal or informal training?

_____ formal (go to 3.1) _____ informal (go to 2.9)

(informal) /

2.9 Describe your informal training process: _____

(formal)

If you carried out more than one inservice program or series of programs, let's look at each one separately.

3.1 When did it occur? _____

3.2 How many hours were involved? (amount of time) _____

3.3 Who attended the training? _____

3.4 Were teachers required to attend, or participate? _____

3.5 Who presented, or provided the training? _____

3.6 What was the nature of the inservice? (topics, etc:) _____

3.7 Were LD children described? _____ yes _____ no _____ yes _____ no

3.8 Were teachers given specific characteristics to look for? _____ yes _____ no _____ yes _____ no

3.9 What characteristics were stressed? _____

3.10 If these were written down, we would like a copy.

<input type="checkbox"/> not written	<input type="checkbox"/> not written
<input type="checkbox"/> will send	<input type="checkbox"/> will send
<input type="checkbox"/> won't send	<input type="checkbox"/> won't send

3.11 Was normal IQ given as a pre-requisite for referral?

☐ yes ☐ no ☐ yes ☐ no

3.12 By what method or methods was the teacher asked to refer? ((read list))

☐ verbal referral

☐ written referral form

☐ rating scale or behavior checklist

☐ other (specify) _____

3.13 To whom does the teacher give the referral or rating form? _____

4.1 What children are the teachers asked to refer? That is, what instructions are they given?

4.2 Is referral a technique used with all ages and at all sites?

☐ yes (go to 4.4) ☐ no (go to 4.3)

4.3 When and where is it used? _____

4.4 Is there a limit to the number of students who can be referred?

☐ yes (go to 4.5) ☐ no (go to 4.6)

4.5 What is the limit? _____

4.6 When can students be referred? _____

4.7 When do you get the bulk of your referrals? _____

4.8 Does the referral involve the use of a rating scale or behavior checklist?

_____ yes, at the initial step (go to 4.9)

_____ yes, later in the screening process (go to 4.9)

_____ no, not at all (go to 5.1)

4.9 Is this a standard form or locally developed?

_____ standard (name) _____ (go to 4.11)

_____ locally developed (name) _____ (go to 4.10)

4.10 Why and by whom was it developed? _____

4.11 Why and by whom was it chosen? _____

4.12 Was it ever used before this project? _____

5.1 What is the next step? _____

5.2 What is the delay before this step is taken? _____

5.3 Where does it take place? _____

5.4 What are the criteria for elimination? _____

5.5 Who decides? _____

5.6 What happens to children eliminated here? (regular class/other services)

5.7 What is the next step?

5.8 What is the delay before this step is taken? _____

5.9 Where does it take place? _____

5.10 What are the criteria for elimination? _____

5.11 Who decides? _____

5.12 What happens to children eliminated here? (regular class/other services) _____

- 5.13 What is the next step? _____
- 5.14 What is the delay before this step is taken? _____
- 5.15 Where does it take place? _____
- 5.16 What are the criteria for elimination? _____
- 5.17 Who decides? _____
- 5.18 What happens to children eliminated here? (regular class/other services) _____
- 5.19 What is the next step? _____
- 5.20 What is the delay before this step is taken? _____
- 5.21 Where does it take place? _____
- 5.22 What are the criteria for elimination? _____
- 5.23 Who decides? _____
- 5.24 What happens to children eliminated here? (regular class/other services) _____
- 6.1 What is the next step? _____
- 6.2 What is the delay before this step is taken? _____
- 6.3 Where does it take place? _____
- 6.4 What are the criteria for elimination? _____
- 6.5 Who decides? _____
- 6.6 What happens to children eliminated here? (regular class/other services) _____
- 6.7 What is the next step? _____
- 6.8 What is the delay before this step is taken? _____
- 6.9 Where does it take place? _____
- 6.10 What are the criteria for elimination? _____
- 6.11 Who decides? _____
- 6.12 What happens to children eliminated here? (regular class/other services) _____

If mass rating also used, go to 6.13
If mass testing also used, go to 8.19
If other process also used, go to 11.19

mass rating

Since you used a mass rating form in your selection process, we want to talk further about it. Again, we would like copies of the form and related materials (if we don't already have them).

6.13 Is a mass rating form used at all sites and at all grades?

_____ yes (go to 6.15) _____ no (go to 6.14)

6.14 On whom or at what sites are rating forms used? _____

6.15 Is this a standard form or locally developed?

_____ standard (name) _____ (go to 6.17)

_____ locally developed (name) _____ (go to 6.16)

6.16 Why and by whom was it developed? _____

_____ (go to 7.1)

6.17 Why and by whom was it chosen? _____

_____ (go to 7.1)

7.1 Was it ever used before this project? _____

7.2 When are students rated? _____

_____ all at once (go to 7.4) _____ several times (go to 7.3)

7.3 When do you get the bulk of your ratings? _____

7.4 What criteria were used after mass rating to determine who goes to the next step? That is, what are the criteria for determining "high risk" children?

7.5 Are these criteria rigid or flexible? _____

7.6 Who makes this decision? _____

7.7 What happens to children eliminated here? (regular class/other services) _____

- 7.8 What is the next step? _____
- 7.9 What is the delay before this step is taken? _____
- 7.10 Where does it take place? _____
- 7.11 What are the criteria for elimination? _____
- 7.12 Who decides? _____
- 7.13 What happens to children eliminated here? (regular class/other services) _____
- 7.14 What is the next step? _____
- 7.15 What is the delay before this step is taken? _____
- 7.16 Where does it take place? _____
- 7.17 What are the criteria for elimination? _____
- 7.18 Who decides? _____
- 7.19 What happens to children eliminated here? (regular class/other services) _____
- 8.1 What is the next step? _____
- 8.2 What is the delay before this step is taken? _____
- 8.3 Where does it take place? _____
- 8.4 What are the criteria for elimination? _____
- 8.5 Who decides? _____
- 8.6 What happens to children eliminated here? (regular class/other services) _____
- 8.7 What is the next step? _____
- 8.8 What is the delay before this step is taken? _____
- 8.9 Where does it take place? _____
- 8.10 What are the criteria for elimination? _____
- 8.11 Who decides? _____
- 8.12 What happens to children eliminated here? (regular class/other services) _____

- 8.13 What is the next step? _____
- 8.14 What is the delay before this step is taken? _____
- 8.15 Where does it take place? _____
- 8.16 What are the criteria for elimination? _____
- 8.17 Who decides? _____
- 8.18 What happens to children eliminated here? (regular class/other services) _____

If mass testing also used, go to 8.19
If other process also used, go to 11.19

mass testing

You mentioned that some children are first noticed because of group testing. We want to pursue the specifics of this. Again, we would like copies of any materials you have developed for this procedure, manuals, tests, etc.

8.19 What test or tests are used for the mass screening?

_____ standardized (go to 9.1) _____ locally developed (go to 9.4)

(standardized)

9.1 Specify test(s): _____

9.2 Why was this test(s) chosen? _____

_____ scores already available from district testing

_____ test booklets available through district

_____ test seemed best for project (and not in use by district)

9.3 Who made the decision to use this test(s)? _____
_____ (go to 9.6)

(locally developed)

9.4 Specify name of instrument: _____

9.5 Why and by whom was it developed? _____

9.6 When is the testing done? _____

9.7 Are all the children at all sites tested on the same instrument?

_____ yes (go to 9.9)

_____ no (go to 9.8)

9.8 Describe differences and criteria: _____

9.9 What age children are or have been tested, and at what sites, in this initial step? _____

_____ preschool (go to 9.10)

_____ no preschool (go to 9.11)

9.10 How do you reach them for testing? _____

9.11 Who administers the mass testing instrument? _____

9.12 Do you provide any special or additional training for the test administrator(s)?

_____ yes (go to 10.1)

_____ no (go to 10.3)

10.1 What kind of training do they receive? ((when, by whom, length))

10.2 Do you think this kind of training is necessary and/or appropriate?
_____ (go to 10.4)

10.3 Why is no training provided or thought to be necessary? _____
_____ (go to 10.4)

10.4 What criteria were used after mass testing to determine who goes to the next step? That is, what are the criteria for determining "high risk" children? _____

10.5 Are these criteria rigid or flexible? _____

10.6 Who makes this decision? _____

10.7 What happens to children eliminated here? (regular class/other services) _____

- 10.8 What is the next step? _____
- 10.9 What is the delay before this step is taken? _____
- 10.10 Where does it take place? _____
- 10.11 What are the criteria for elimination? _____
- 10.12 Who decides? _____
- 10.13 What happens to children eliminated here? (regular class/other services) _____
- 10.14 What is the next step? _____
- 10.15 What is the delay before this step is taken? _____
- 10.16 Where does it take place? _____
- 10.17 What are the criteria for elimination? _____
- 10.18 Who decides? _____
- 10.19 What happens to children eliminated here? (regular class/other services) _____
- 11.1 What is the next step? _____
- 11.2 What is the delay before this step is taken? _____
- 11.3 Where does it take place? _____
- 11.4 What are the criteria for elimination? _____
- 11.5 Who decides? _____
- 11.6 What happens to children eliminated here? (regular class/other services) _____
- 11.7 What is the next step? _____
- 11.8 What is the delay before this step is taken? _____
- 11.9 Where does it take place? _____
- 11.10 What are the criteria for elimination? _____
- 11.11 Who decides? _____
- 11.12 What happens to children eliminated here? (regular class/other services) _____

- 11.13 What is the next step? _____
- 11.14 What is the delay before this step is taken? _____
- 11.15 Where does it take place? _____
- 11.16 What are the criteria for elimination? _____
- 11.17 Who decides? _____
- 11.18 What happens to children eliminated here? (regular class/other services) _____

other processes

Sometimes the usual procedures just aren't adequate, and some other selection process must be used, in order to allow eligible children into the project. We want to ask a few questions to find out about these.

- 11.19 Did any of the children who received remedial services from the project get into the program any other way, than by referral, rating, or testing?
- _____ yes (go to 11.20) _____ no (go to 12.2)

11.20 Specify how: _____

- 12.1 Can you estimate how many such instances there have been--children now receiving services who entered the selection process other than by the standard way as before? _____
- _____

changes in selection process

If year I project, go to 12.5
If year II or III project, go to 12.2

- 12.2 Is your current selection procedure exactly the same as the one used during the first year of the project? That is, do children this year enter the program in the same way as before?

_____ yes (go to 12.5) _____ no (go to 12.3)

12.3 What changes have been made? _____

12.4 Are you satisfied with the change? _____

12.5 Do you contemplate making any changes for next year?

____ yes (go to 12.6)

____ no (go to 12.8)

12.6 What are they? _____

12.7 Why change? _____

pool

We want to now take a step back to get a picture of the overall pool of children from whom the LD children are drawn.

12.8 From how many school districts are children screened for the program?

12.9 Are all the schools within these districts included?

____ yes, a total of _____ (go to 12.12)

____ no, a total of _____ (go to 12.10)

12.10 How was it decided which schools would be involved? That is, on what basis were some eliminated? _____

12.11 Who decided this? _____

12.12 In the selected schools, what age(s) children are eligible? _____

13.1 Are all children of this age in the participating schools eligible, or are some excluded even before the selection process begins?

____ all are eligible (go to 13.3)

____ some are excluded initially (go to 13.2)

13.2 Who is excluded from the initial selection process? _____

(if handicapped children excluded, go to 13.4; otherwise, 13.3)

13.3 Does this mean that children who have been previously identified as handicapped are also eligible for selection?

13.4 What is normally done for children who previously have been identified as handicapped? Are any of these services available in the district(s)?

- | | |
|----------------------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> EMR classes | <input type="checkbox"/> speech |
| <input type="checkbox"/> TMR classes | <input type="checkbox"/> visually impaired |
| <input type="checkbox"/> BD, EH, ED classes | <input type="checkbox"/> reading consultant or remedial reading classes |
| <input type="checkbox"/> physically and/or multiply handicapped | <input type="checkbox"/> gifted |
| <input type="checkbox"/> deaf or hard of hearing | <input type="checkbox"/> homebound/hospital |
| <input type="checkbox"/> arrangements with community private schools | |

13.5 Through what process(es) were these previously identified children found?

Now let's go back and reconsider those children who were identified as LD.

13.5 Are all the children who are screened and found to be eligible then allowed to receive project remedial services?

- ☐ yes (go to 13.6) ☐ no (go to 13.7)

13.6 You mean everyone eligible is being served? No schools are excluded? No control groups are used? No waiting list! Enough facilities to handle every eligible child?

- ☐ all are served (go to 14.1) ☐ some not served (go to 13.7)

13.7 Explain how the devision is made; that is, who decides which children will receive remedial services and what are the criteria?

quantitative summary

The final questions involve quantitative data, which you may not have at your finger-tips. In that case, it would be helpful if you could make note of the needed figures and send us the information after the interview.

14.1 What is the total enrollment in the included schools and the included ages?

14.2 How many children were tested, rated, or referred, at that initial step? _____

14.3 How many children, from this group, were ultimately found to be LD and therefore eligible for the program? _____

14.4 How many children have received remediation through the program this year? _____

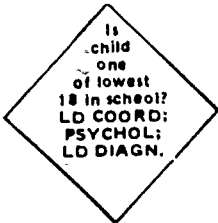
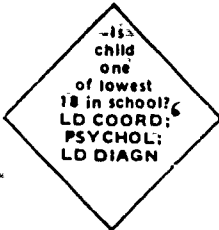
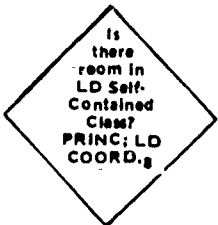

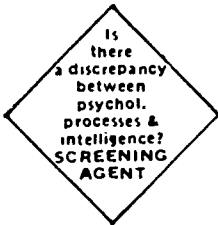
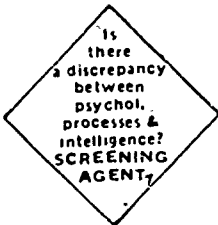
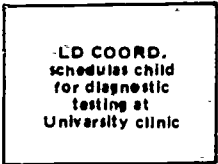
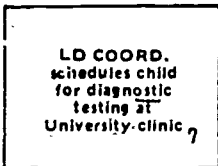
That concludes the questions; we may need to contact you after the tape has been transcribed, if we find something that is still unclear.

In any case, you have been very helpful; we're glad you were willing to spend this amount of time with us. Do you have any questions or anything you'd like to add or comment on? _____

(If more materials or quantitative data is to be sent, go over this list))

FLOW CHARTS AND NOTATIONS

ERRATA FOR CHARTS AND NOTATIONS

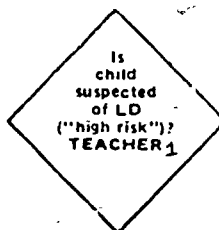
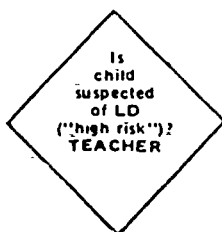
<u>Page</u>	<u>Error</u>	<u>Correction</u>	
B-2			add notation #6
B-4			correct #8 to read #9
J-4			add notation #7
O-3			add notation #7

Page

Error

Correction

P-1



add notation #1

FF-4



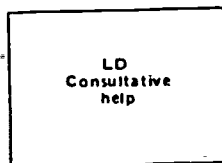
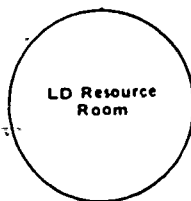
add notation #6

HH-1



change ID to IQ

JJ-3



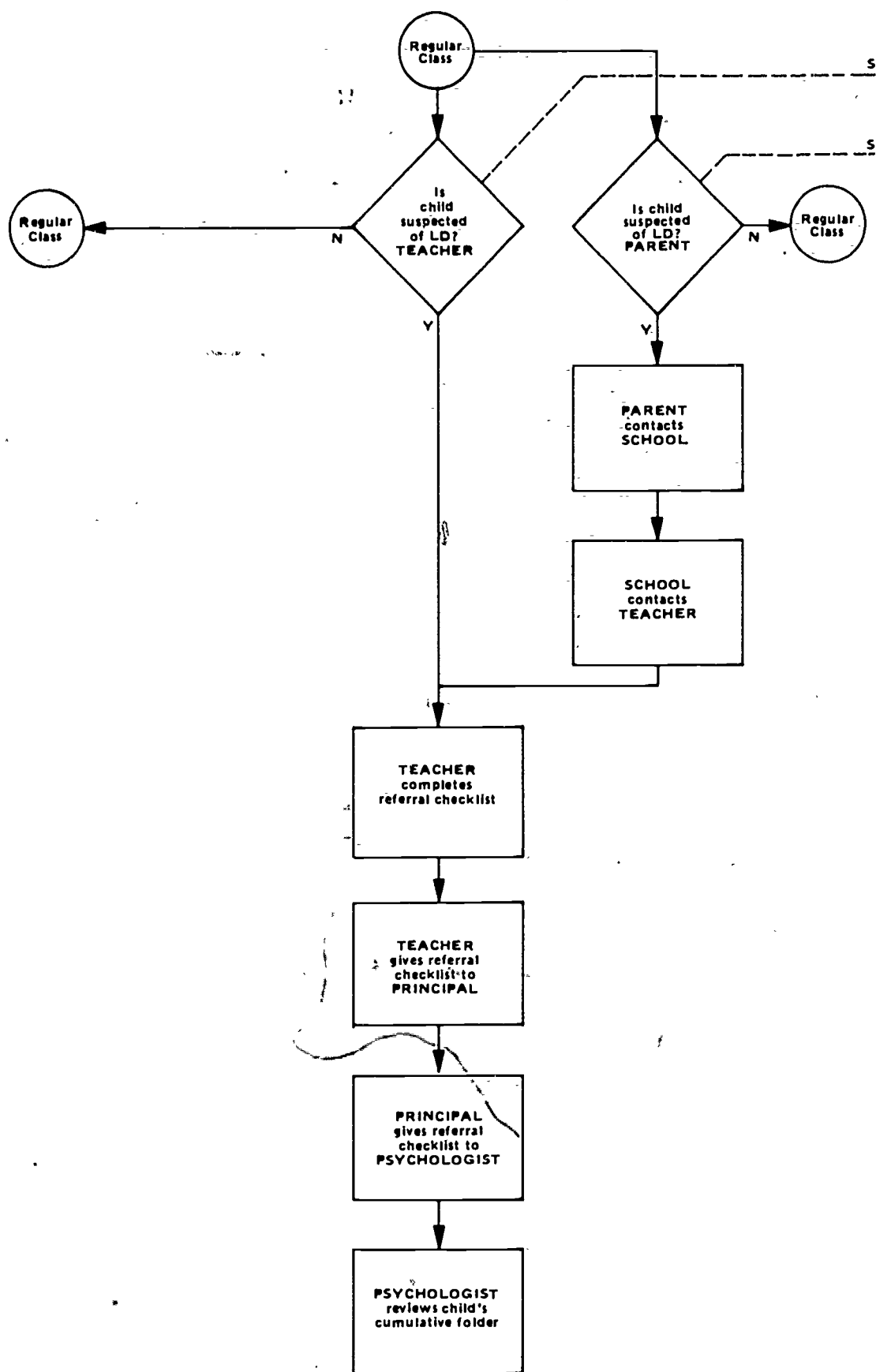
change to:

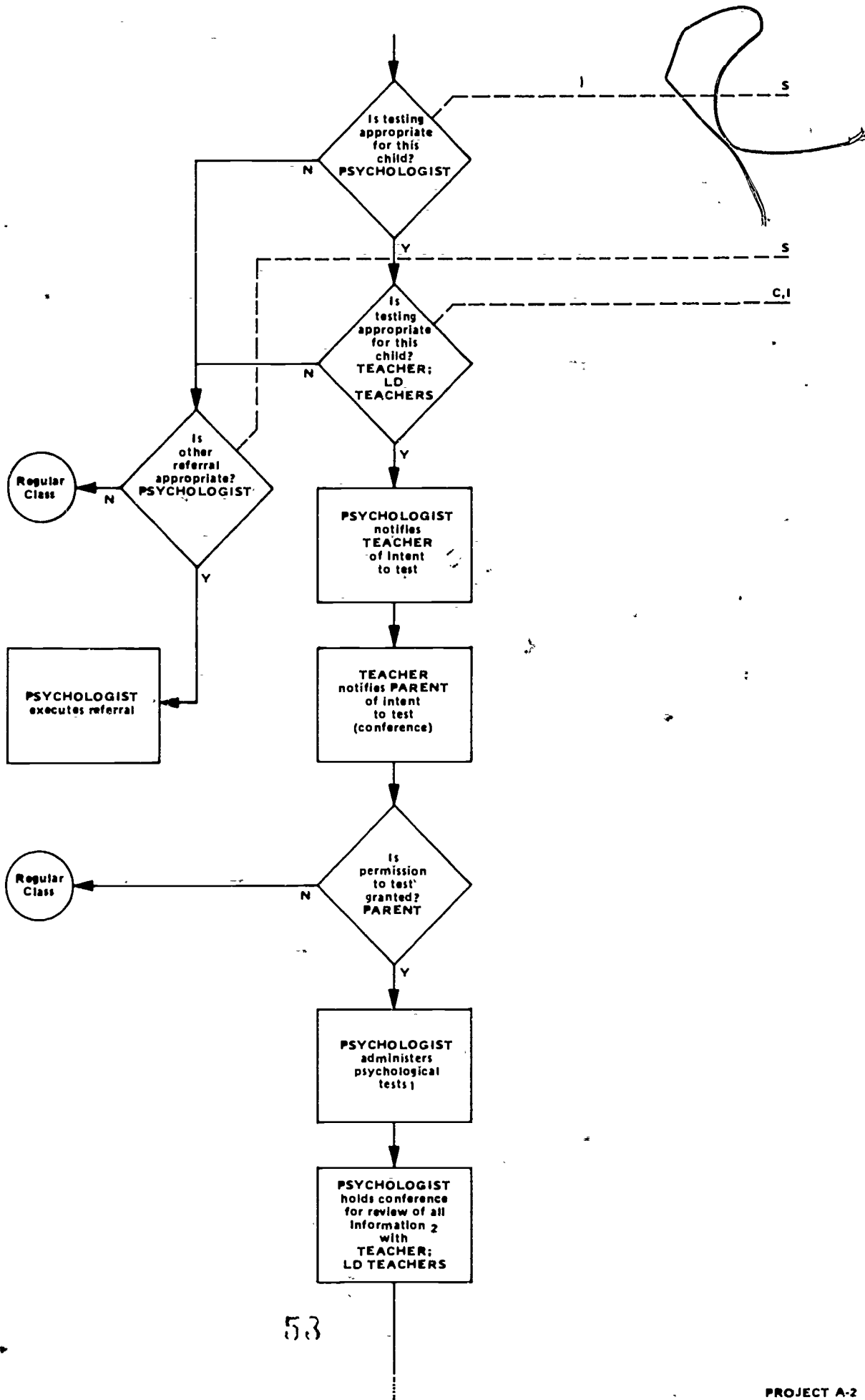


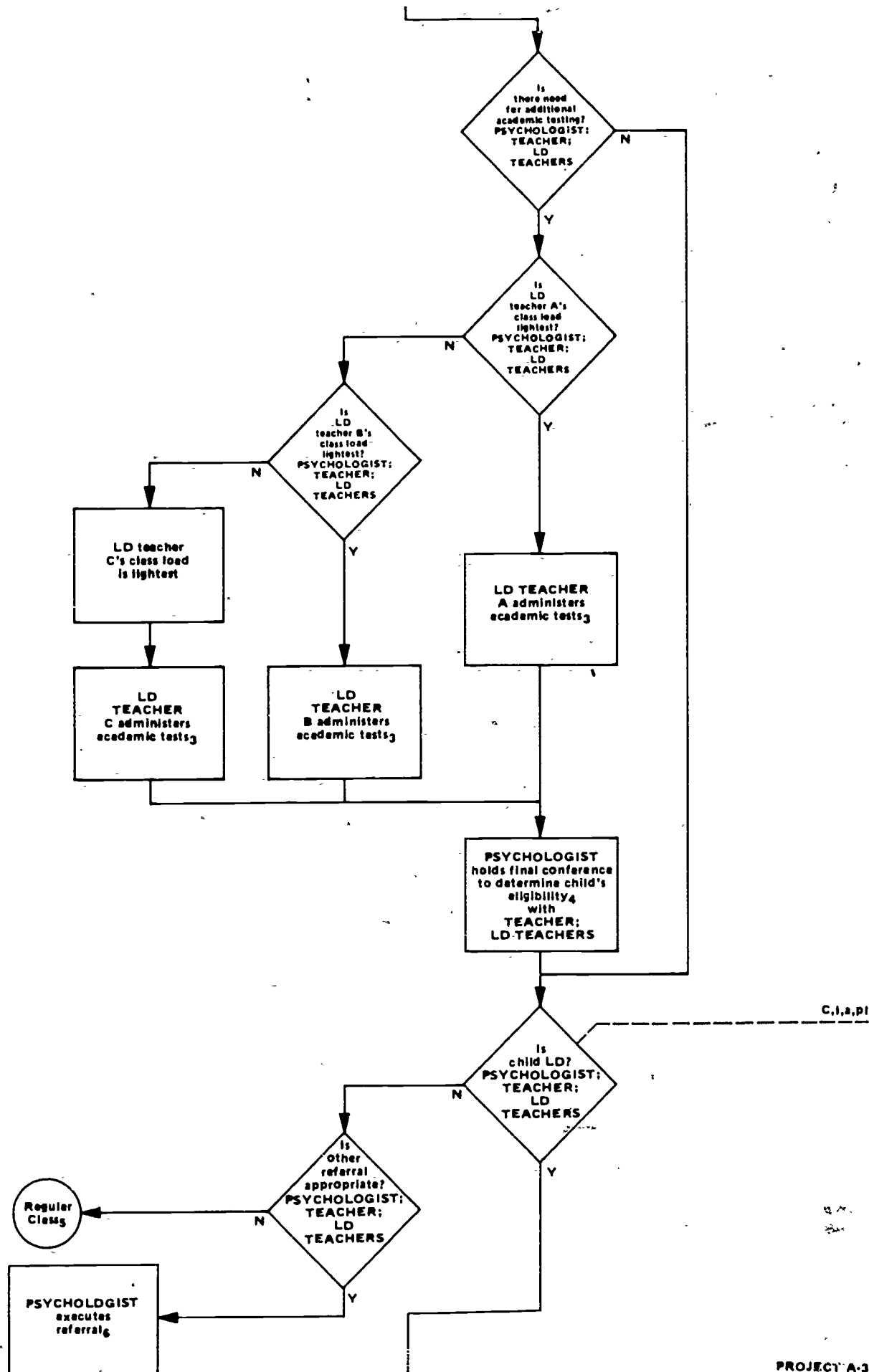
LL-4

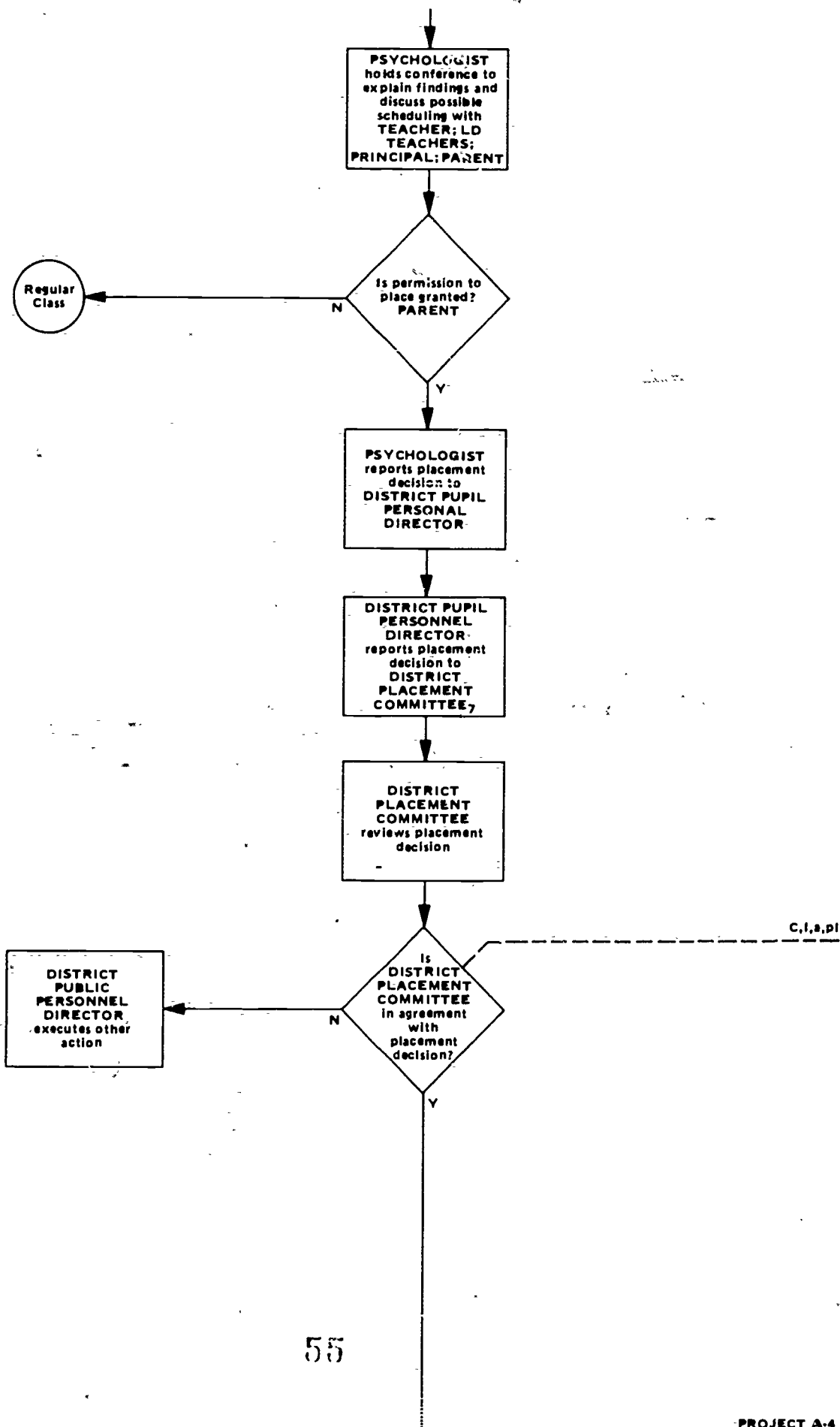


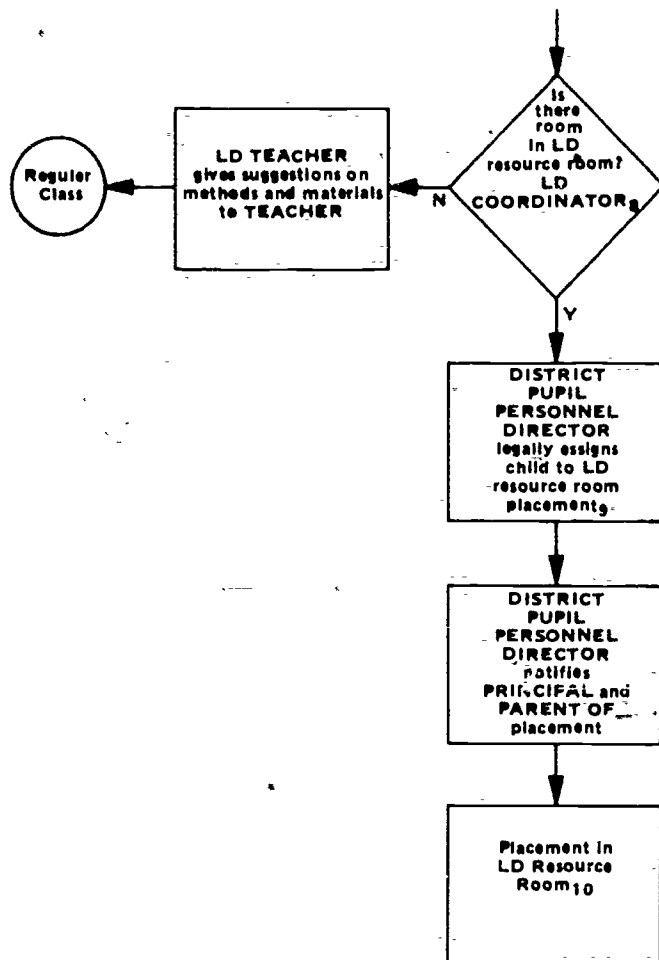
correct #3 to #5











I. GENERAL INFORMATION

1. Project Code Letter: A
2. Delivery System for Intervention: LD Resource Room (Grades 1-5)
3. Initial Entry: Referral (Teacher/Parent)
4. Personnel Involved in Decision-making:
 - a) Eligibility decisions: Parent
Teacher
Psychologist
LD Teachers (3)
District Placement Committee
 - b) Constraining decisions: Parent
Psychologist

II. SPECIAL NOTATIONS

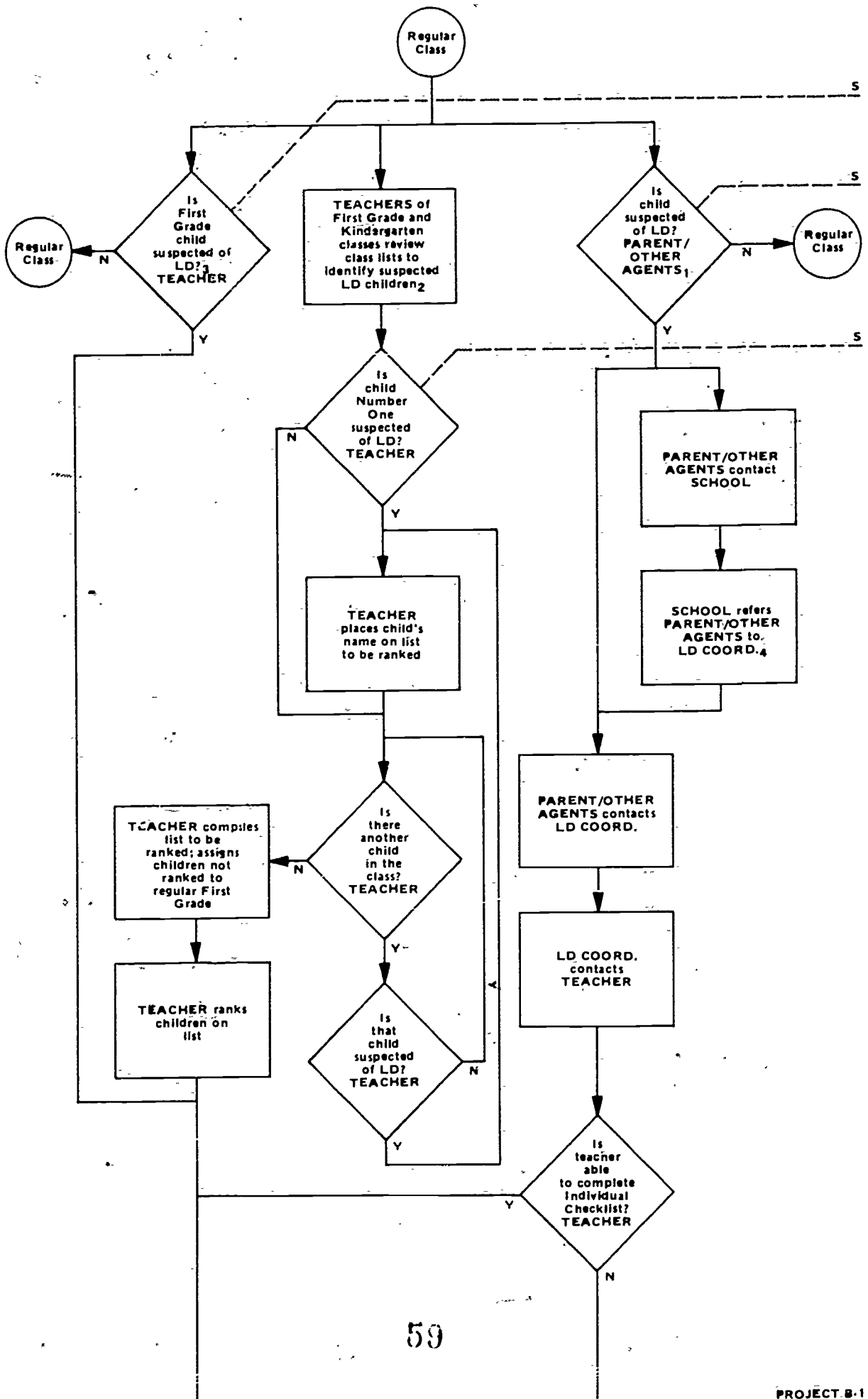
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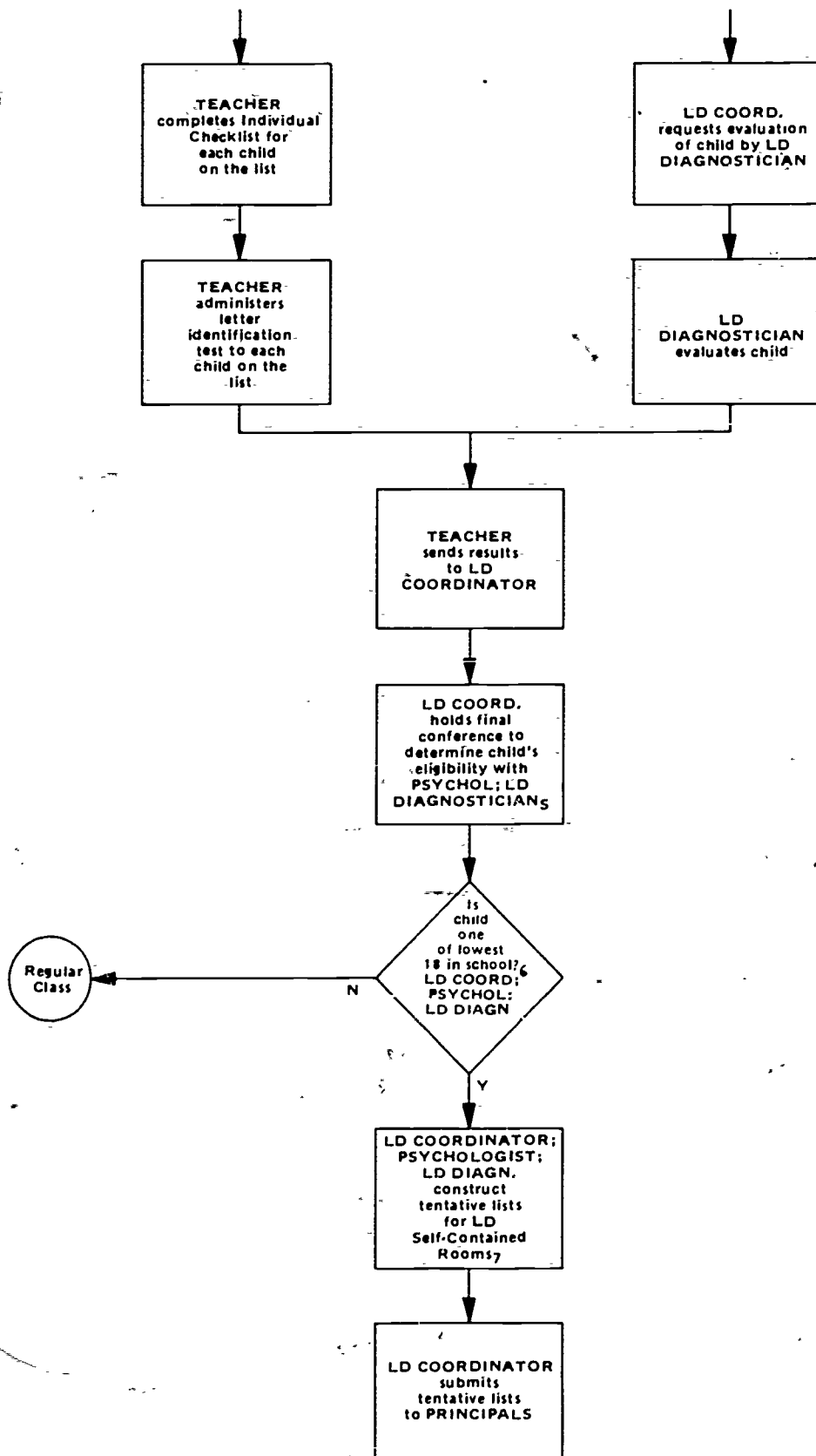
1. WISC or Binet
ITPA
(Bender-Gestalt)
2. referral checklist;
academic achievement testing;
other information in accumulative order;
psychological test results
3. (Gallistel-Ellis Phonics Tests)
(Sucher-Allred Reading Comprehension)
(Key-Math)
(PIAT)
(Others)* *the Piers-Harris Self-Concept test is also given.
4. Team looks for "scatter" in WISC results (particularly Verbal vs. Performance IQs), deficits in academic achievement, and discrepancies in psychological processes (e.g., 2 years behind overall Mental Age in California Mental Maturity or PMA).
5. Occasionally a child is given supportive help from a counselor, even though he remains in the regular classroom.
6. Other referrals include: Services for MR; ED; Neurological examination; Title I Reading Program.
7. Composition of this committee is not completely known. It is apparently headed by the District Pupil Personnel Director and includes Psychologists and Psychometrists from the District. The Title VI-G Director sits on this

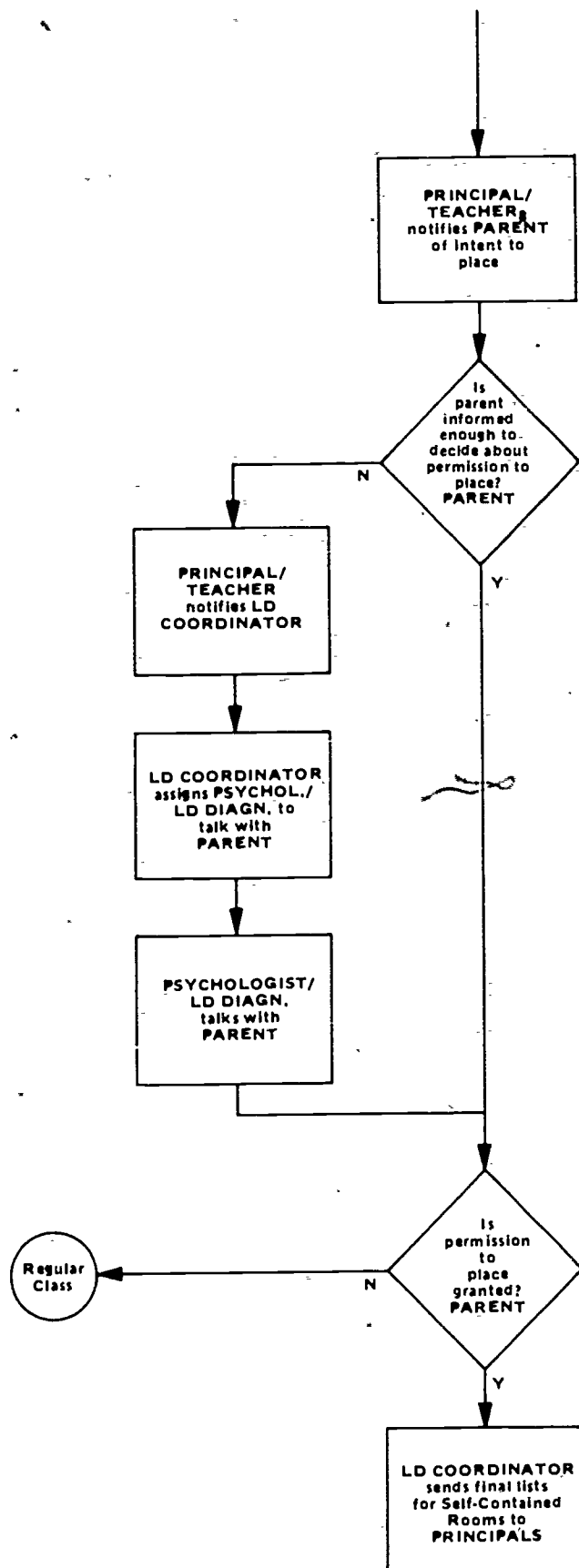
committee. (No child has ever been rejected for delivery of special intervention by this committee, but several have been referred to EMH services).

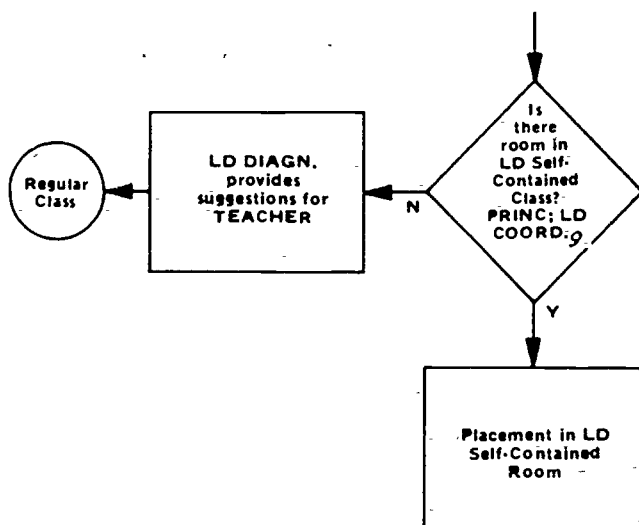
8. The LD Coordinator is the local Title VI-G Project Director.
9. The District Pupil Personnel Director files the necessary official documents for the state.
10. Some children are worked within "Self-Concept" groups. Also, some extended exams are being done for visual acuity, auditory acuity, etc.











I. GENERAL INFORMATION

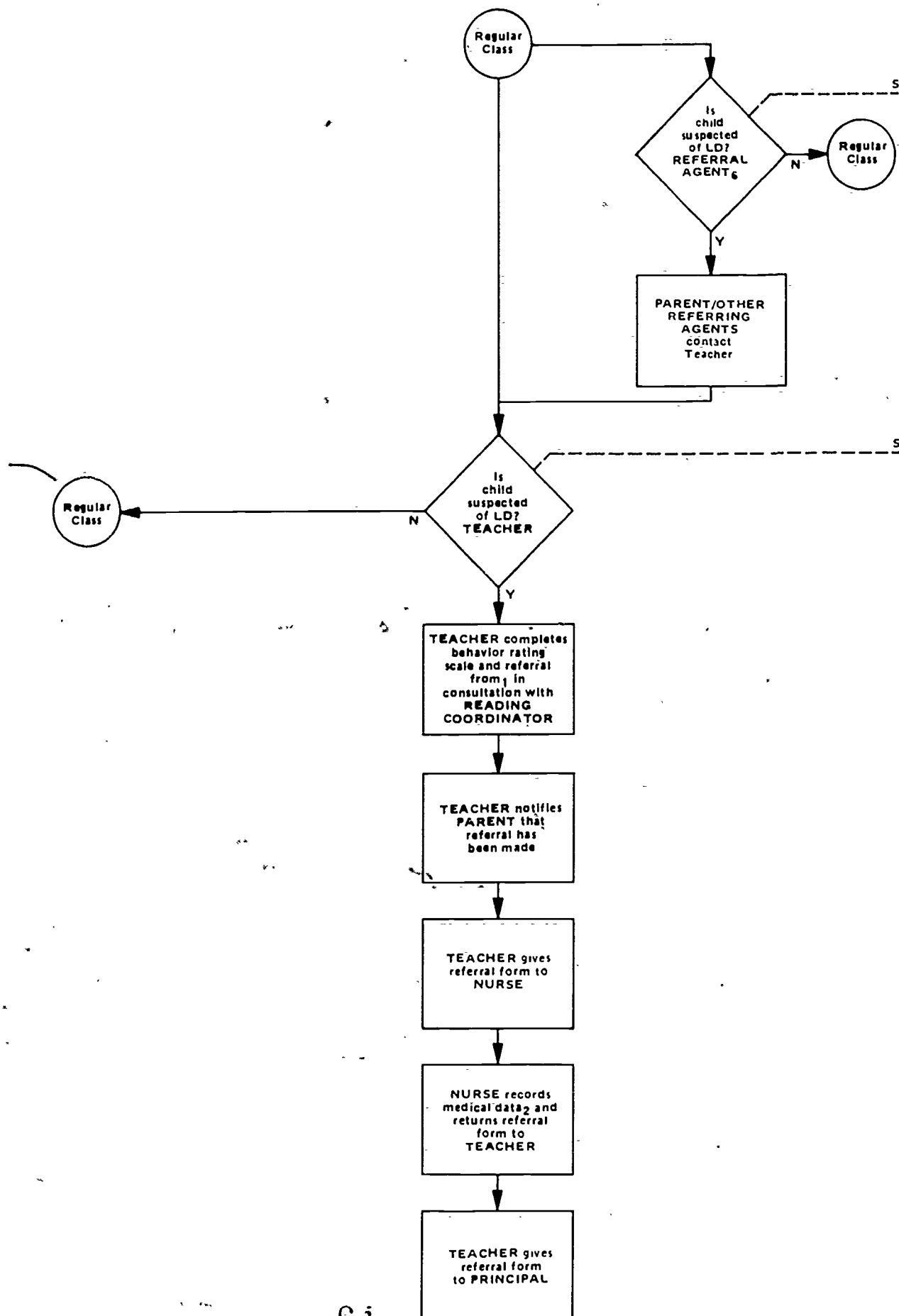
1. Project Code Letter: B
2. Delivery System for Intervention: LD Self-Contained Room (1st Grade)
3. Initial Entry: Referral (Teacher/Parent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent
Other Agents
Teacher
 - b) Constraining decisions: LD Coordinator
Psychologist
LD Diagnostician
Teacher

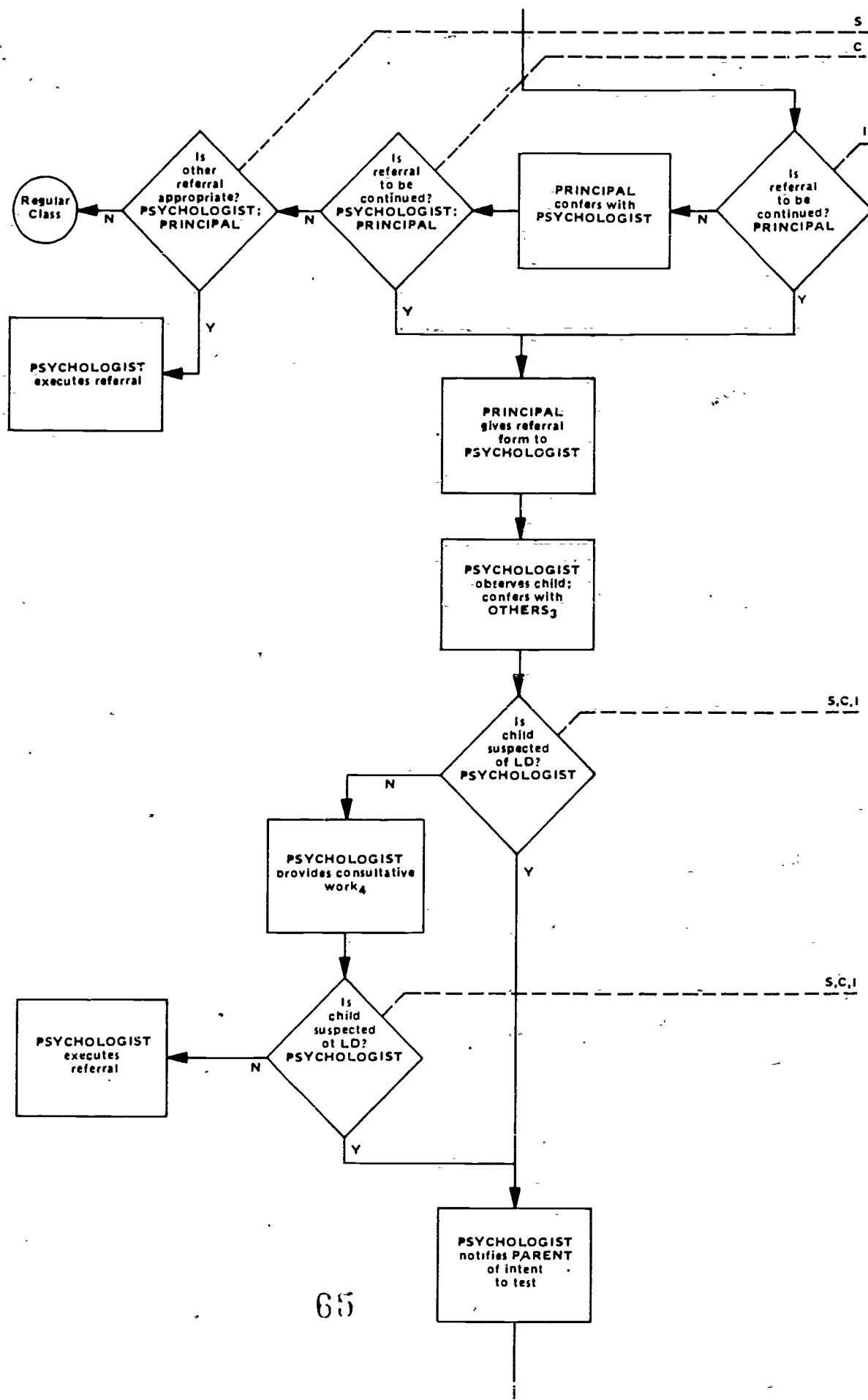
II. SPECIAL NOTATIONS

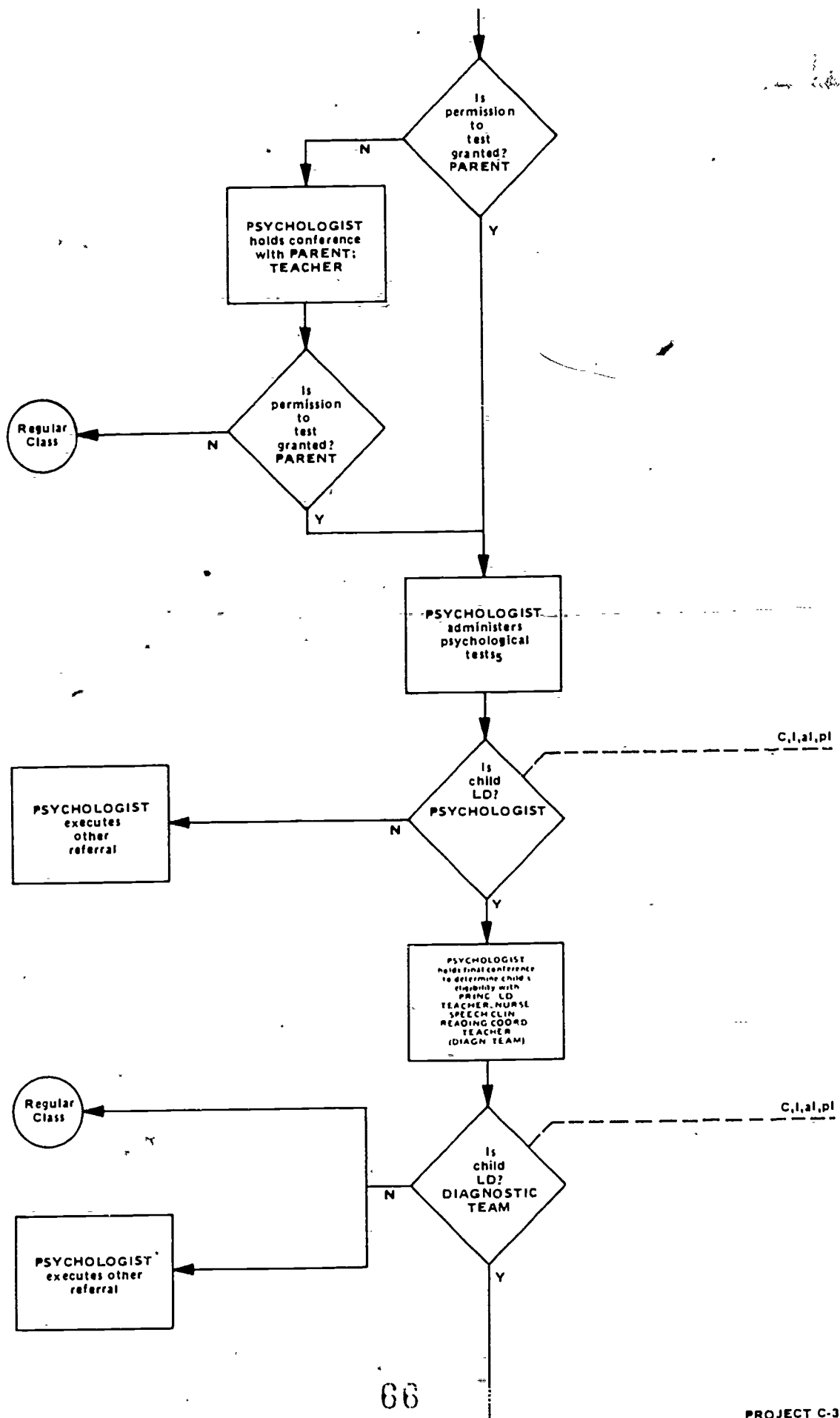
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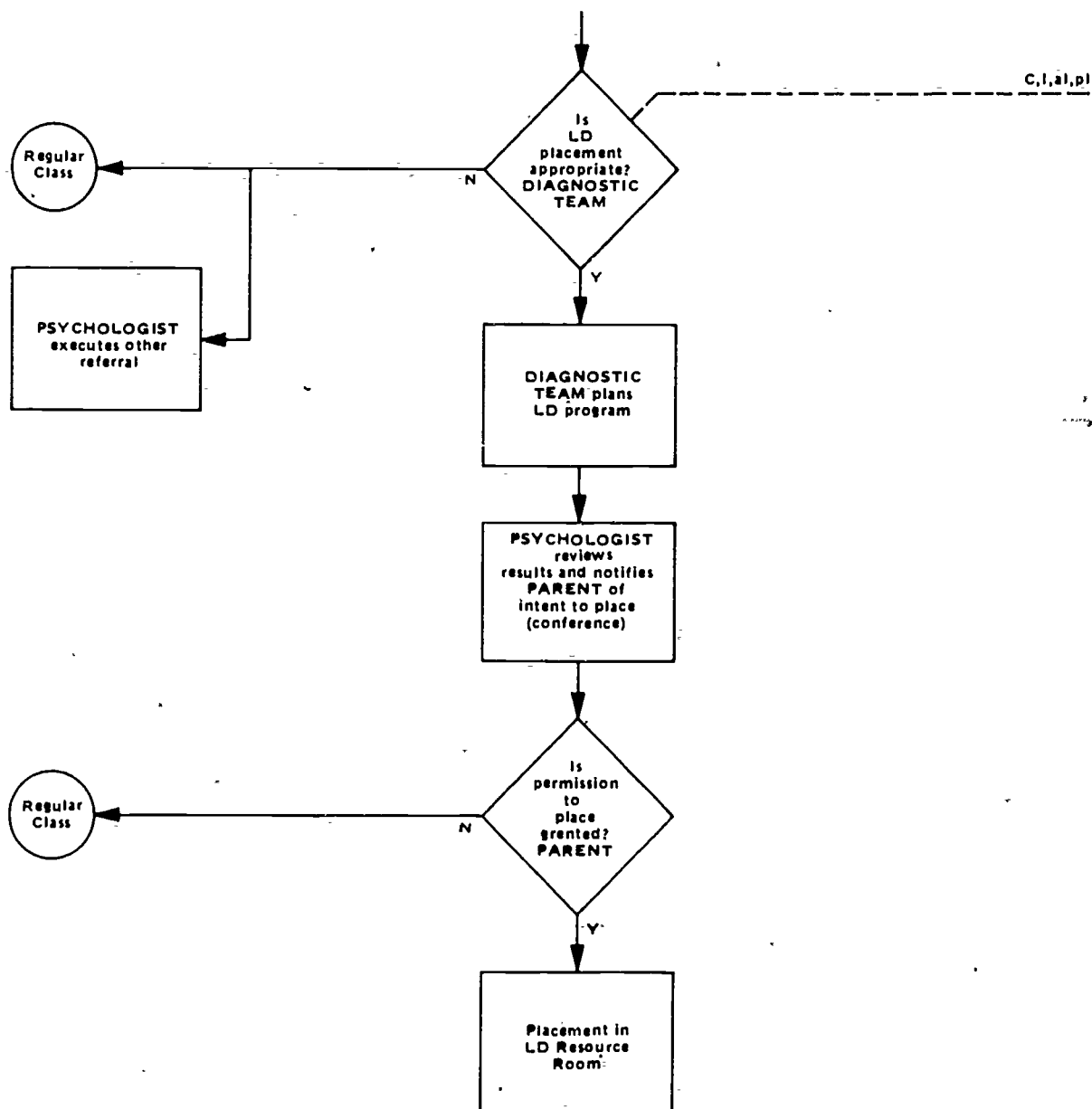
1. Other agents include Psychologist, Principal, etc.
2. Kindergarten screening is done in the Spring;
First Grade screening is done in the Fall.
3. Referral can be at any time.
4. LD Coordinator is the local Title VI-G Project Director.
5. Information reviewed includes Teacher Rankings, Individual Checklist Scores, Teachers' comments, and Letter Identification Test Scores.
6. The exact criteria for determining the "lowest 18" are uncertain. It is apparently a group decision with Teacher Ranking, Individual Checklist Scores, Letter Identification Test Scores and Teachers' comments being considered roughly in that order; the number "18" is based on the enrollment limit for the special classes; SCHOOL in this instance means two schools in which one class is held.
7. A separate list is made up for each Principal in the schools where LD Resource Rooms are available.
8. Principal determines whether s/he or teacher will make contact.
9. Quota is not merely whether the LD Self-contained room roster is complete; if child is in paired school, transportation may be a factor.

Project B-5









I. GENERAL INFORMATION

1. Project Code Letter: C
2. Delivery System for Intervention: LD Resource Room (Grades K-8)
3. Initial Entry: Referral (Teacher/Parent/Principal, Nurse, Speech Clinician/
LD Specialists/Reading Coordination)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions:

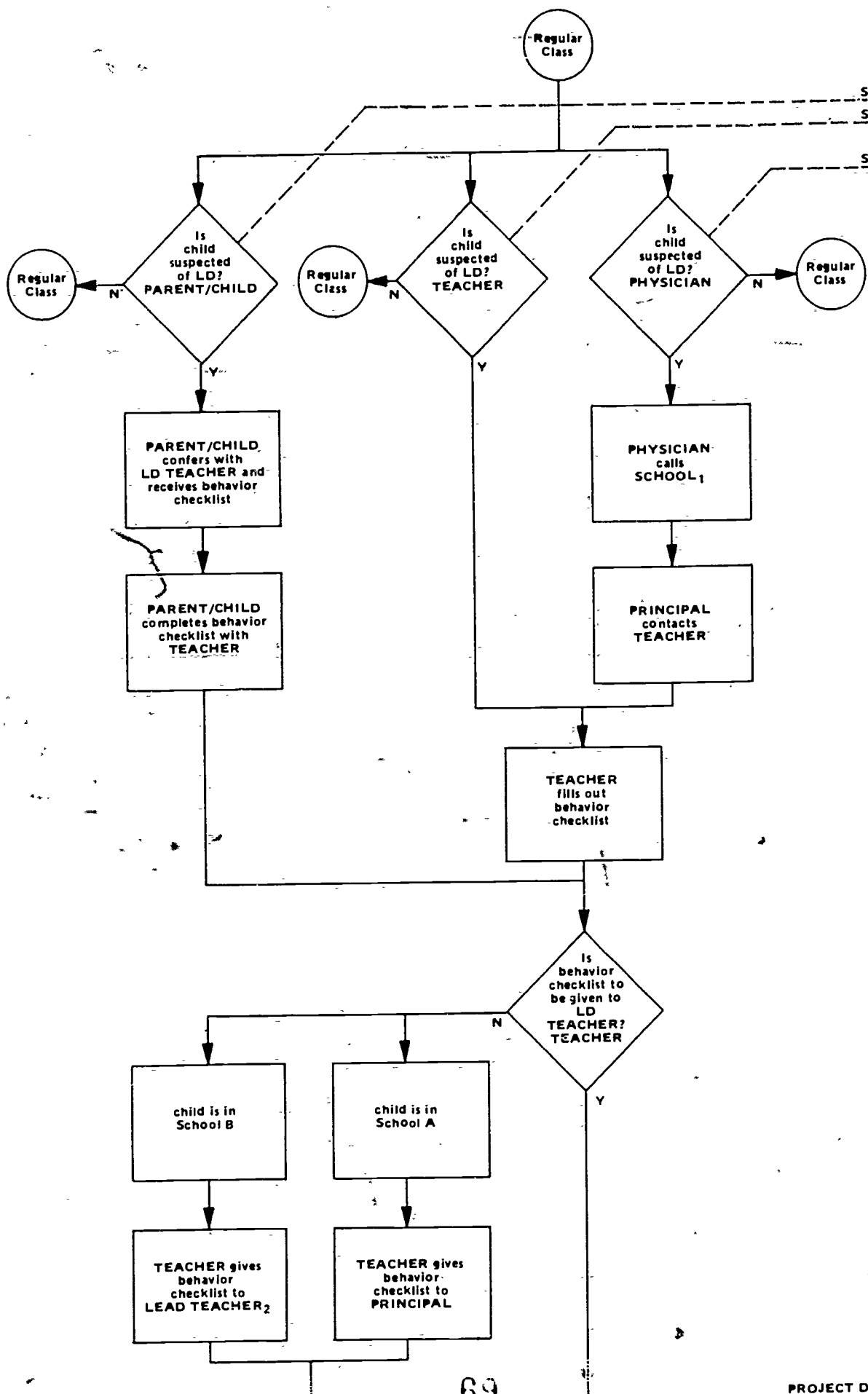
Parent	Nurse
Principal	LD Teacher
Psychologist	Speech Clinician
Reading Coordinator	Child
 - b) Constraining decisions: Parent
Diagnostic Team

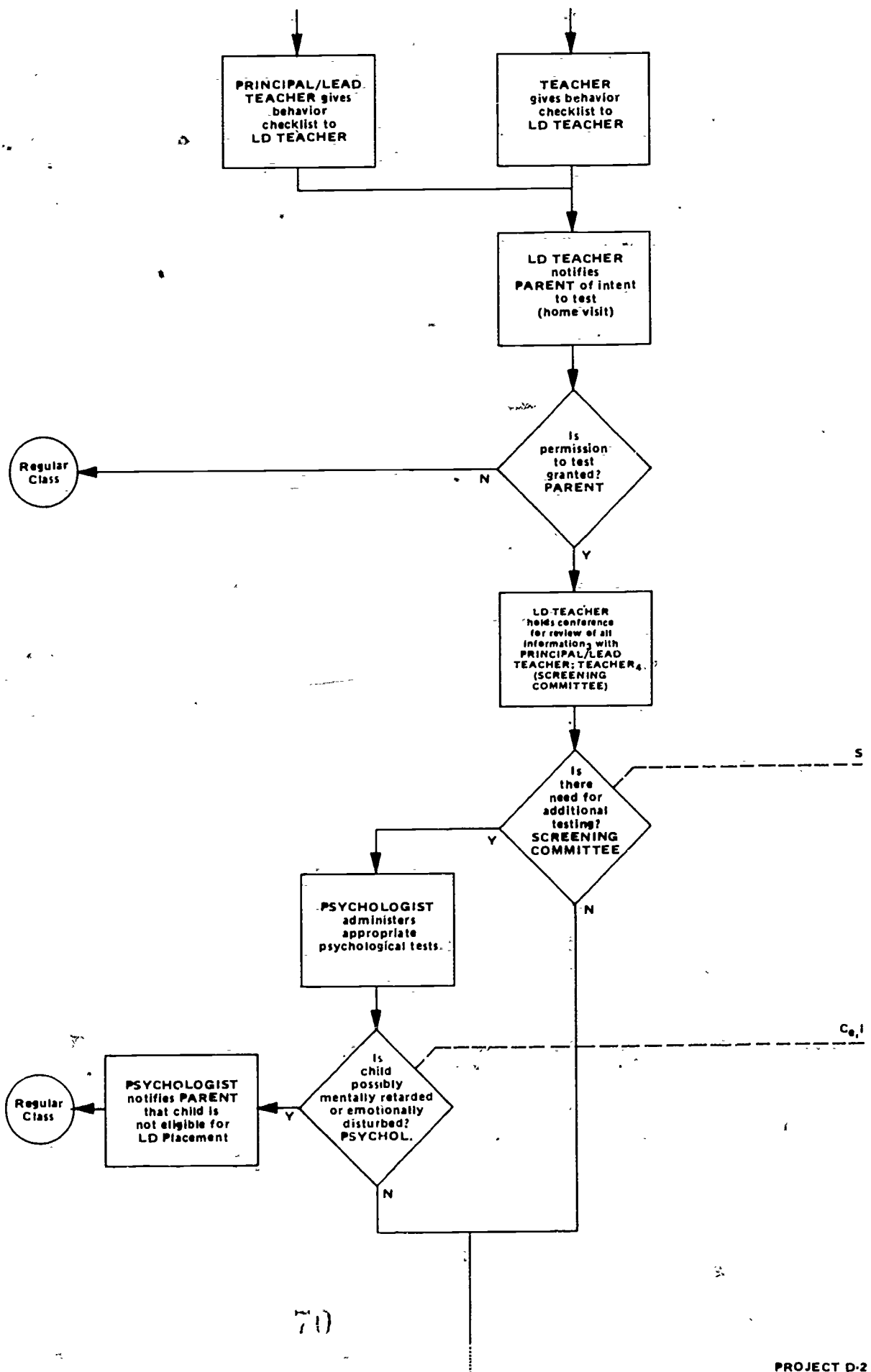
II. SPECIAL NOTATIONS

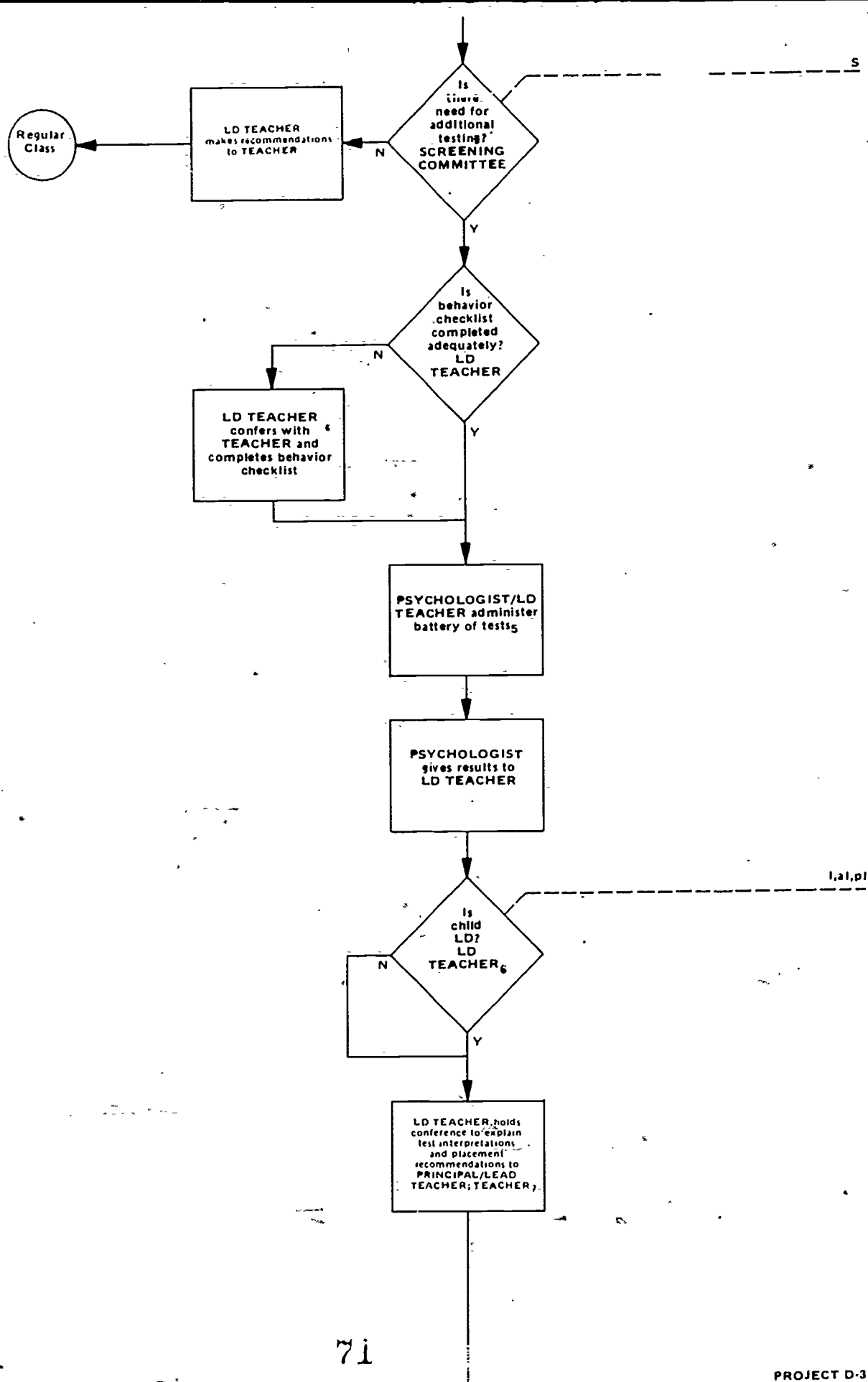
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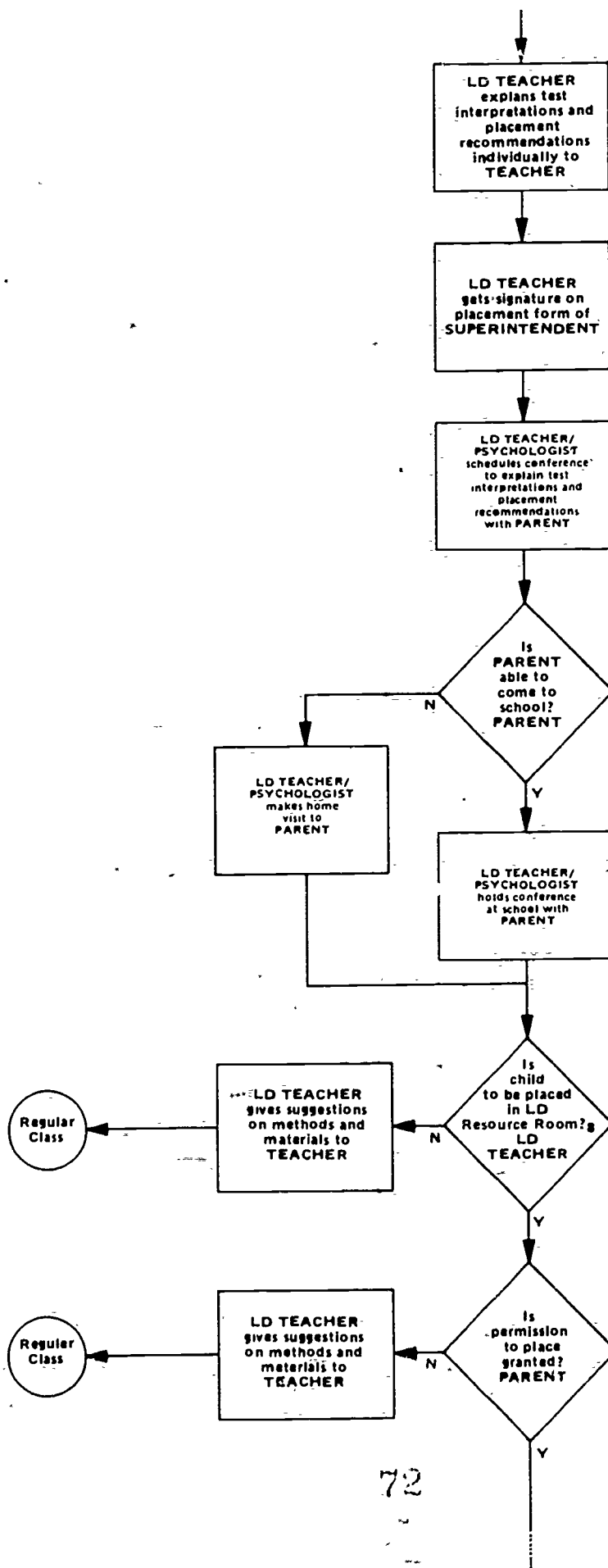
1. Referral form includes tabulation of results from previous psychological and/or achievement testing from cumulative records.
2. Medical data includes results of vision and hearing screening, use of medication and any other pertinent medical data.
3. Usually confers with Teacher, Reading Coordinator, anyone who has had contact with the child before; observation may be in the classroom; occasionally the Psychologist will do some work with the child.
4. Psychologist himself (or another psychologist in the office of Pupil Personnel Services) consults with teacher, parent, special services personnel, or others to determine placement and/or services other than those for LD. If the child is to be considered for LD placement, he must take part in a complete psychodiagnostic evaluation.
5. Testing includes individual intelligence test, plus whatever array of test the psychologist chooses to assess a complete profile of learning skills e.g. language, auditory, visual, motor, integration - essentially a processing model) and achievement.
6. Referral Agents include: Parent, Principal, Nurse, Speech Clinician, LD Specialist, Reading Coordinator, Child.

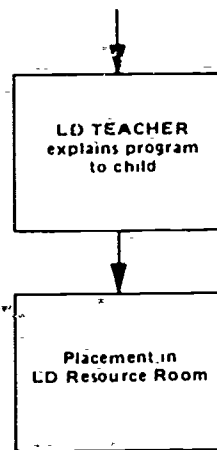
Project C-5











I. GENERAL INFORMATION.

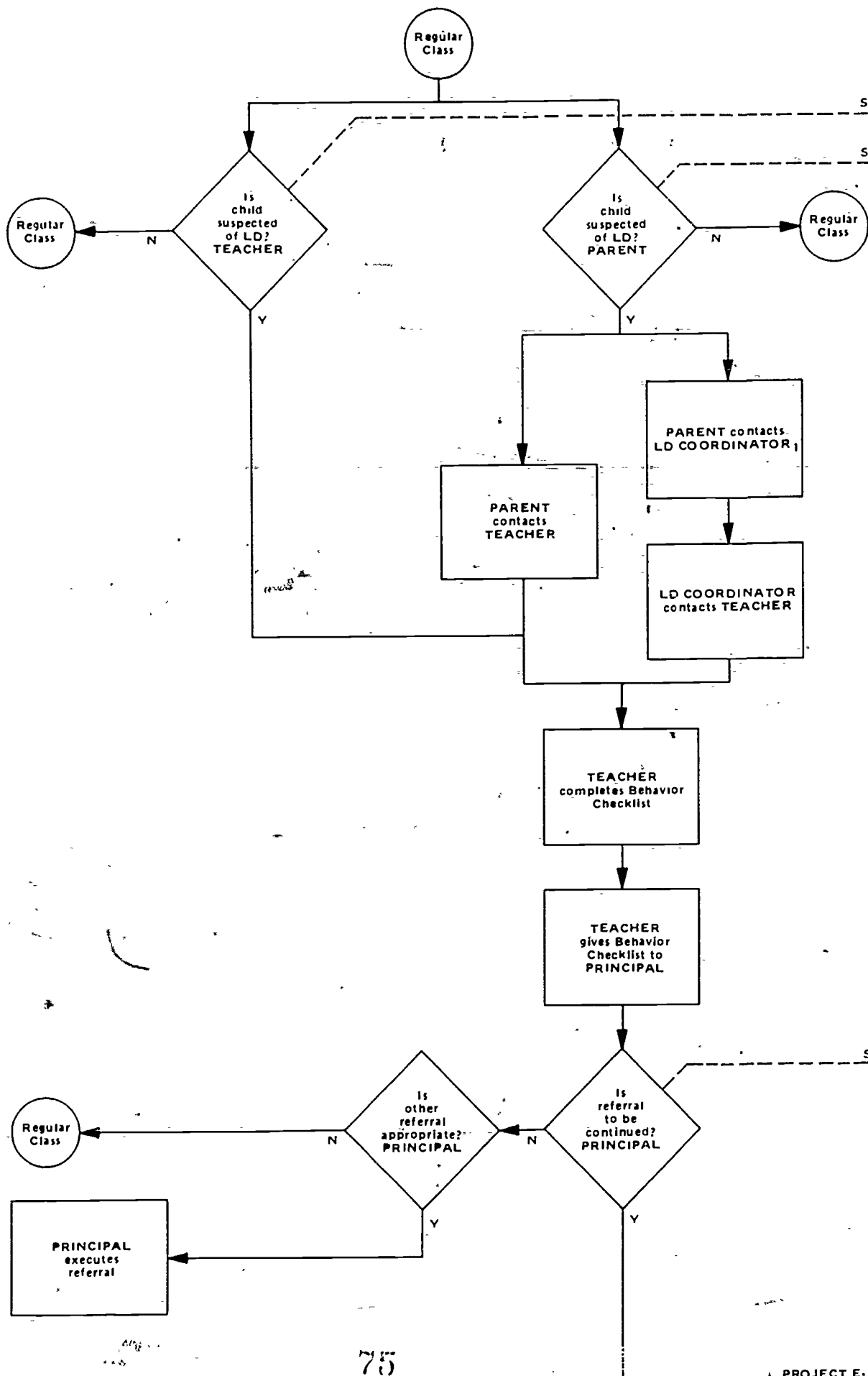
1. Project Code Letter: D
2. Delivery System for Intervention: LD Resource Room (Grades K-8)
3. Initial Entry: Referral (Teacher/Parent/Physician/Child)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Physician Screening Committee
Parent LD Teacher
Teacher Placement Team
Psychologist
 - b) Constraining decisions: Teacher
Parent
LD Teacher

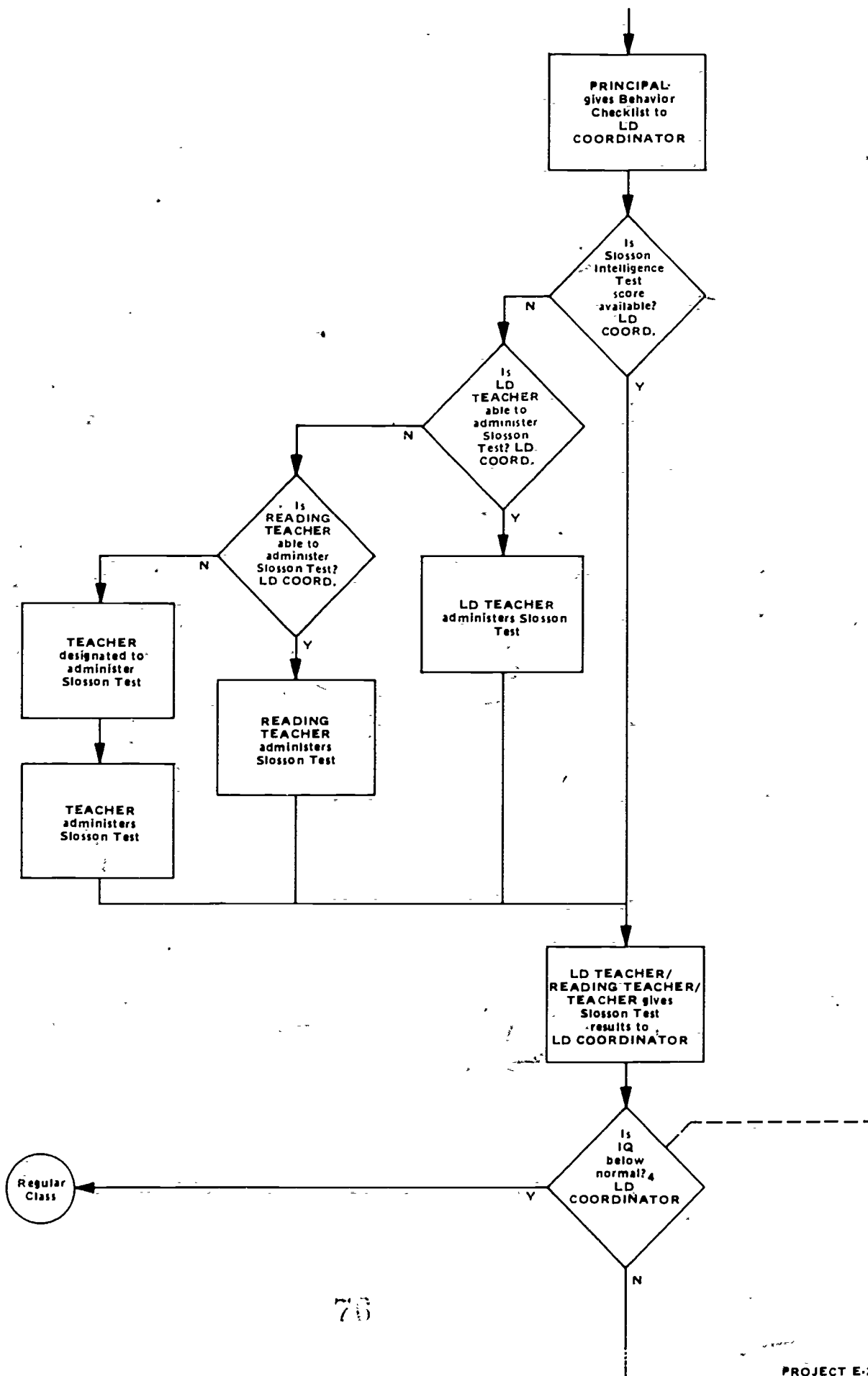
II. SPECIAL NOTATIONS

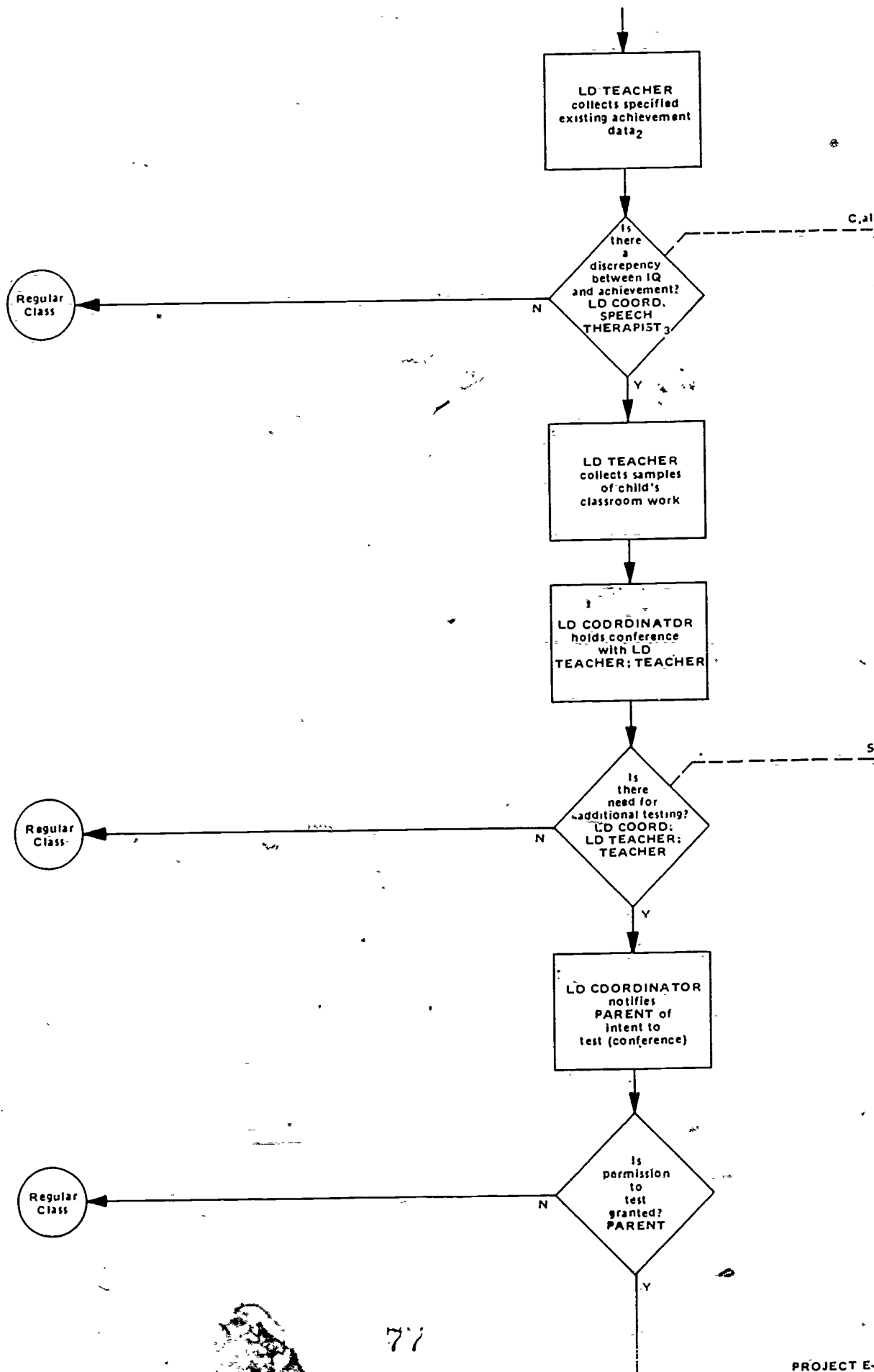
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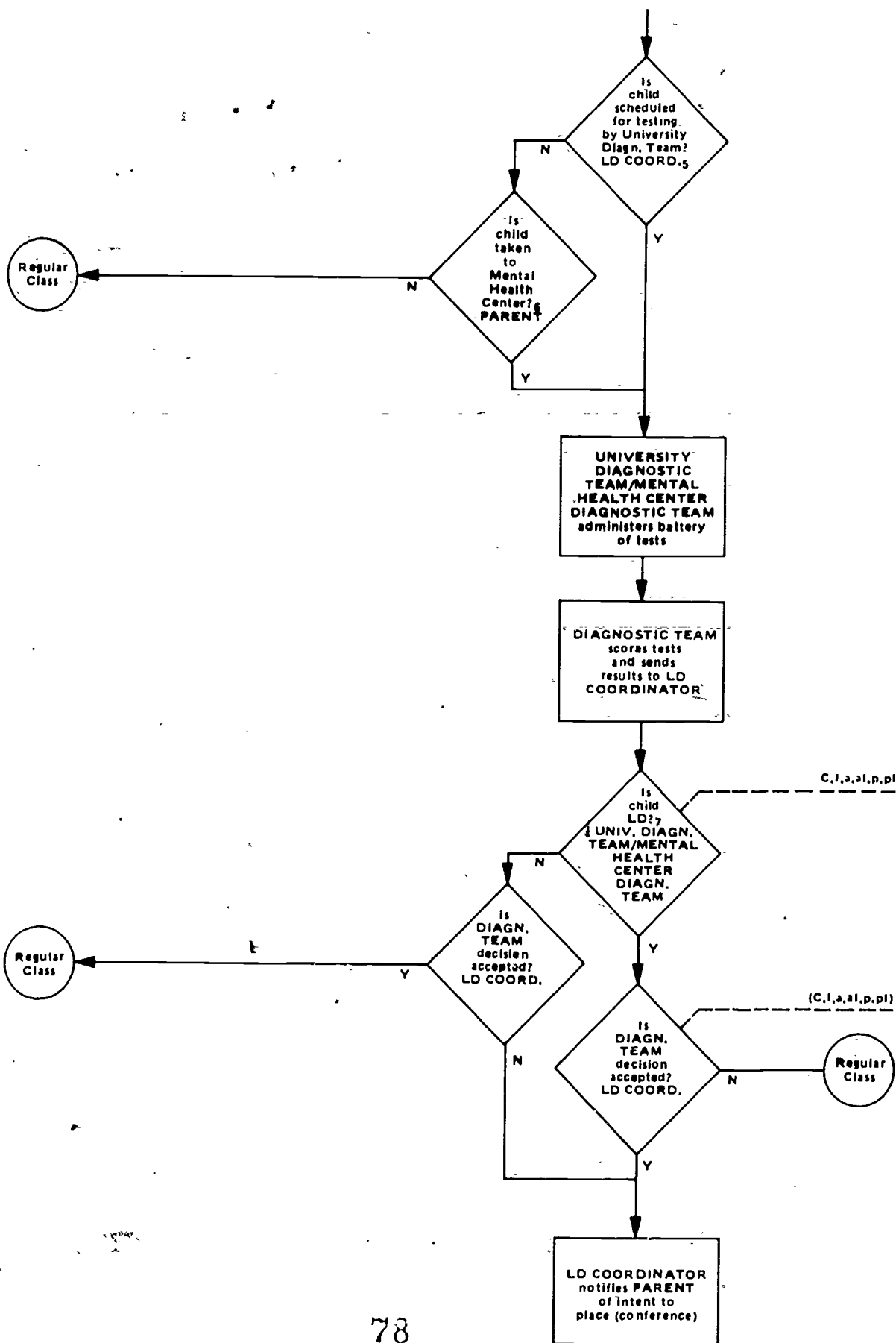
1. Usually this is the PRINCIPAL.
2. The Lead Teacher is simply the teacher who has worked in that particular school the longest.
3. Information includes child's complete file, i.e., medical information (usually slim) academic record, etc.
4. Occasionally the other LD teacher in the schools will come and/or the county nurse and/or psychologist.
5. Battery of tests may include Durrell Reading Analysis, WISC, Binet, TAT, Bender, Key-Math, Wepman, WRAT, Slosson, ITPA, PPVT, Frostig, Lincoln-Oseretsky, Purdue Perceptual Motor, etc. Choice of tests is made by PSYCHOLOGIST and LD Teacher (who also serves as consultant and diagnostician).
6. Child is considered LD if there is discrepancy between intelligence and achievement or between intelligence and any of the psychological processes measured.
7. Whenever possible the Psychologist attends.
8. Occasionally a child is placed in the LD Resource Room even though he does not fully qualify; these are instances where no other service is available for whatever problems emerge.

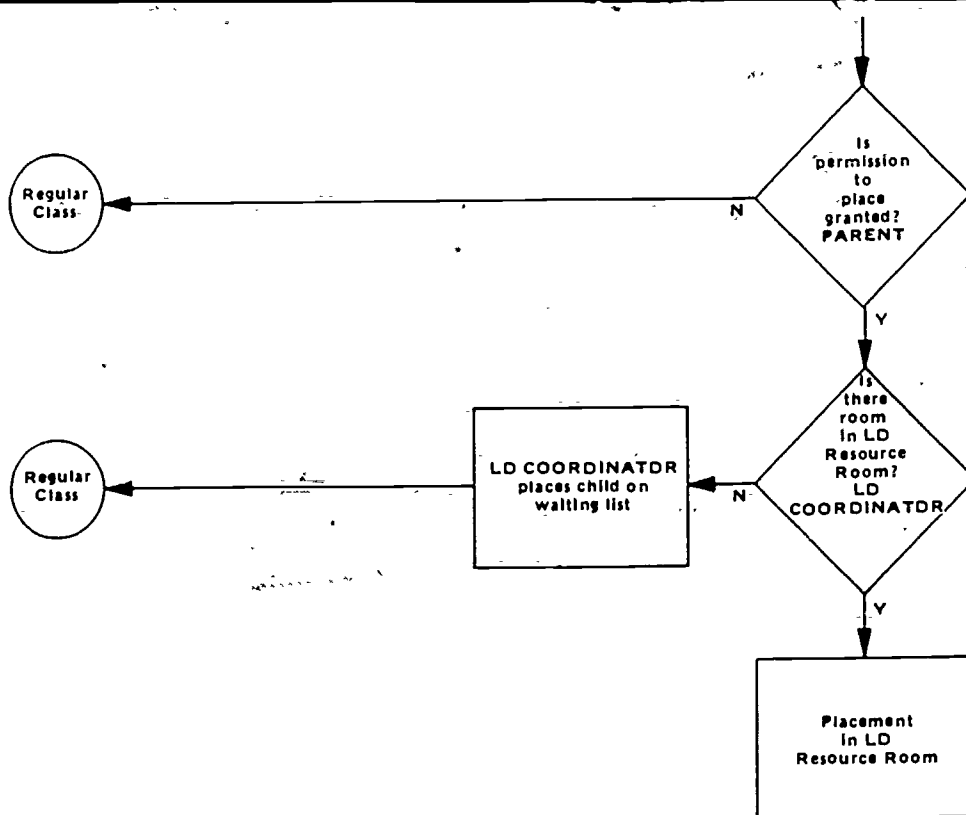
Project D-6











I. GENERAL INFORMATION

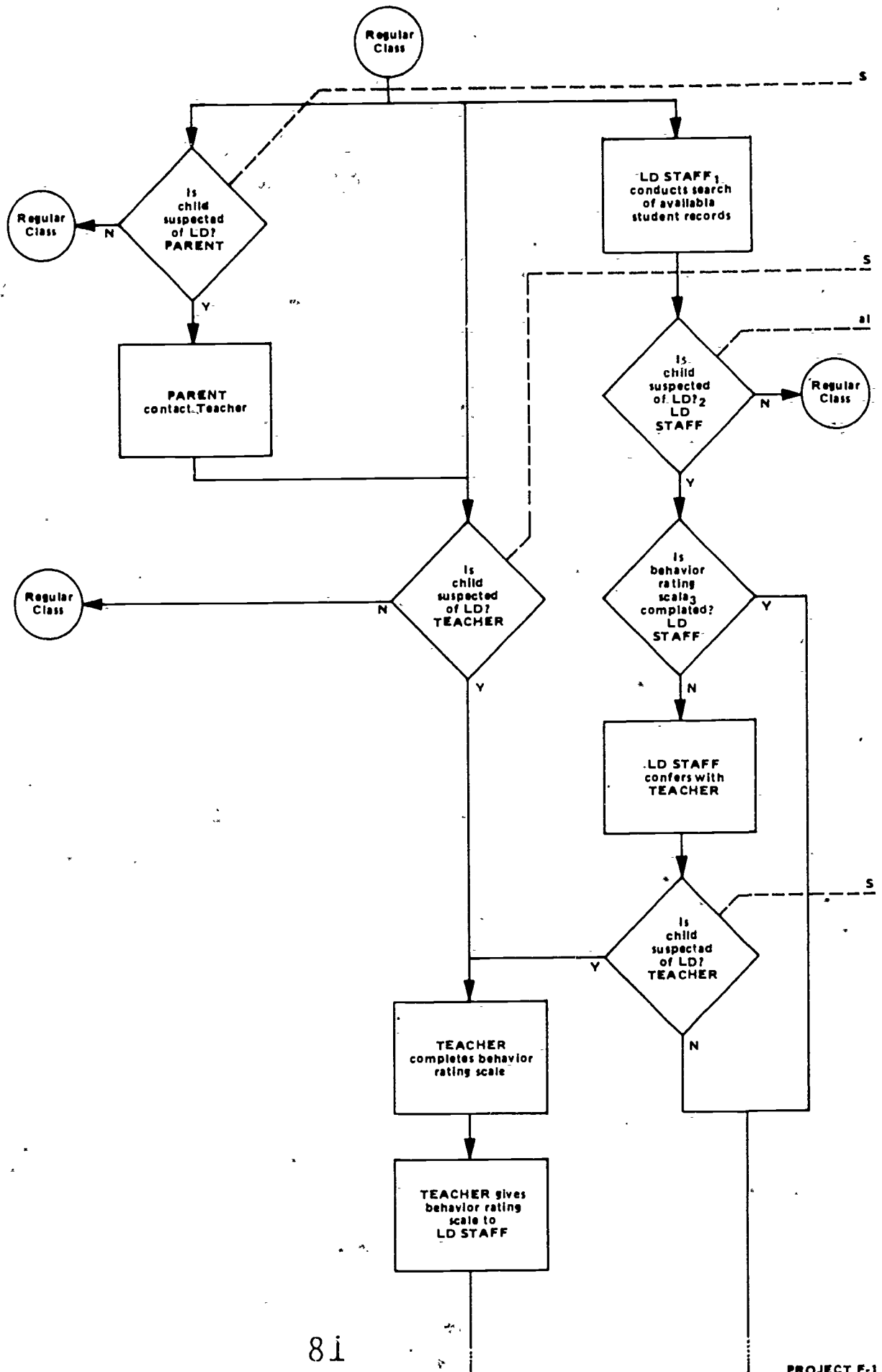
1. Project Code Letter: E
2. Delivery System for Intervention: LD Resource Room (Grades 1-6)
3. Initial Entry: Referral (Teacher/Parent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent
Teacher
Principal
University Diagnostic Team
Mental Health Center
Diagnostic Team
LD Coordinator
Speech Therapist
LD Teacher
 - b) Constraining decisions: LD Coordinator
Parent

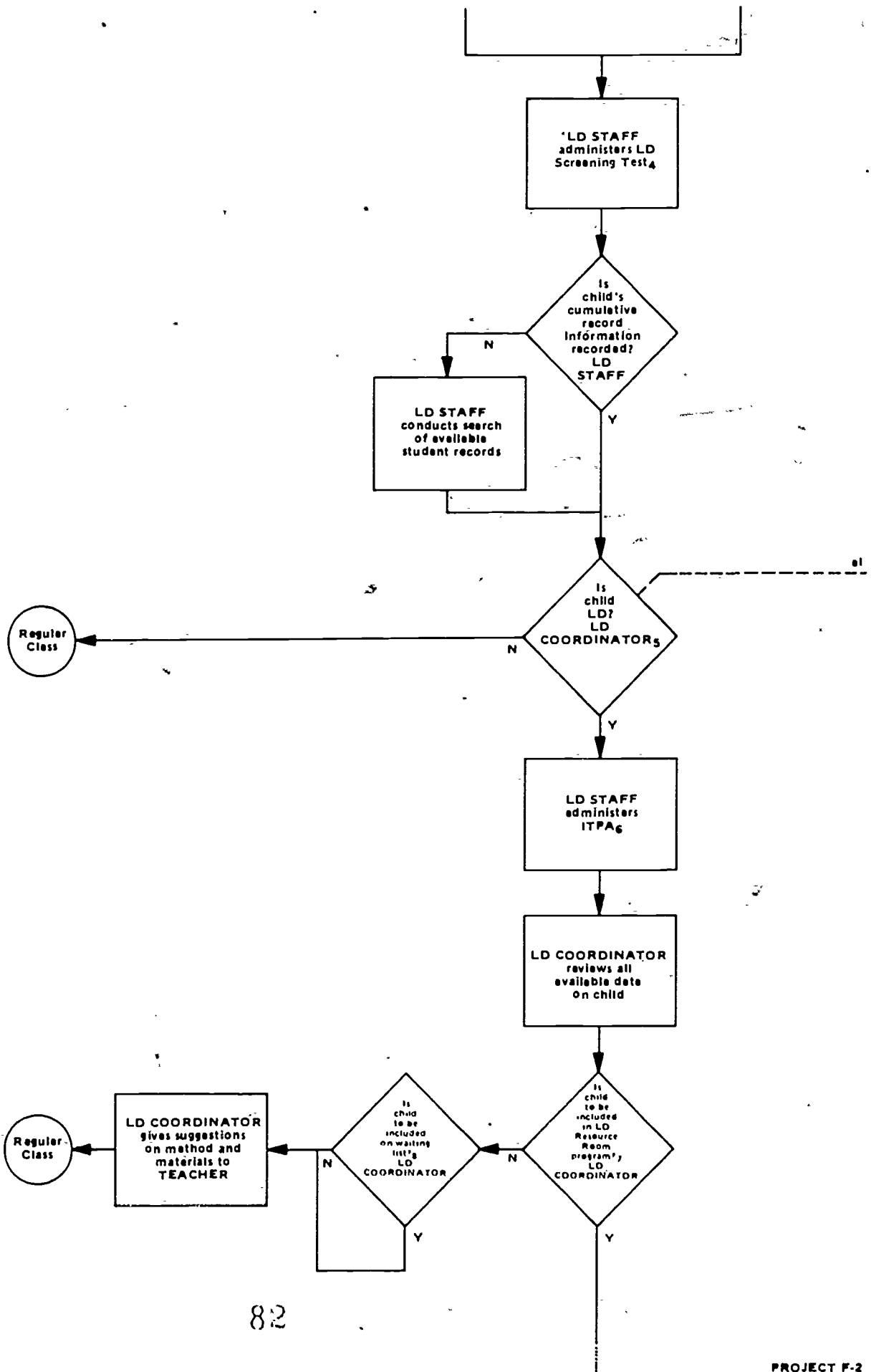
II. SPECIAL NOTATIONS

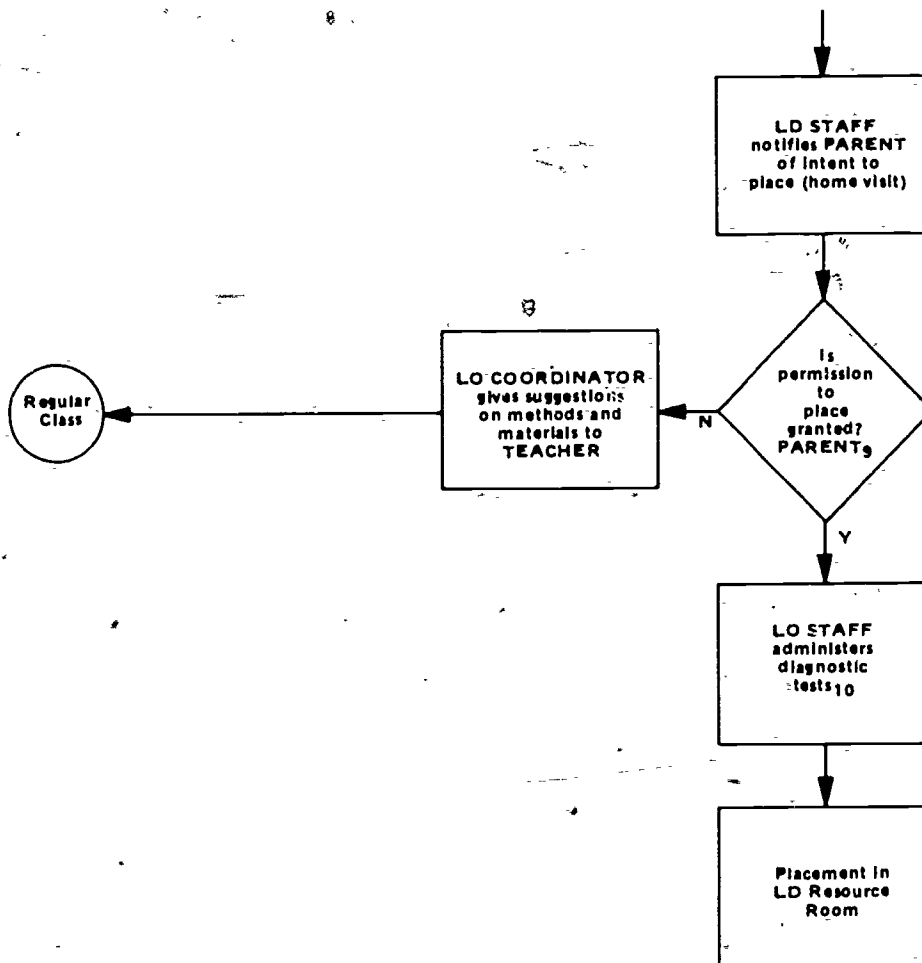
(footnotes apply to notations on flow-chart)

1. LD Coordinator is the local Title VI-G Project Director.
2. Data include grade achievement scores; Iowa Test of Basic Skills scores, (4th grade only), Gates-MacGinitie scores; Teachers' comments.
3. No set criteria were established for discrepancy; apparently the LD Coordinator called in the Speech Therapist and they jointly decided whether discrepancies were significant (NOTE: the Speech Therapist was certified in LD, but was not functioning in the project, nor as an LD Teacher).
4. Low IQ is 80 or below.
5. The University Diagnostic Team is scheduled to come to the schools at periodic intervals; the child is scheduled for that testing session if possible, otherwise he must make a special appointment at the University or go to the local Mental Health Center.
6. The parents must take the child to the local Mental Health Center for equivilant testing.
(Tests given at either site include: WISC, Bender, WRAT, ITPA, and others).
7. We are unsure about how the Diagnostic Teams describe whether the child is LD. Therefore, in our coding we have indicated that all types of "inclusion decisions" are made.

Project E-6







I. GENERAL INFORMATION

1. Project Code Letter: F
2. Delivery System for Intervention: LD Resource Room (Grades 1-6)
3. Initial Entry: Mass Screening (Cumulative Records Search)
Referral (Teacher/Parent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: LD Staff
Teacher
LD Coordinator
 - b) Constraining decisions: LD Staff
LD Coordinator
Parent

II. SPECIAL NOTATIONS

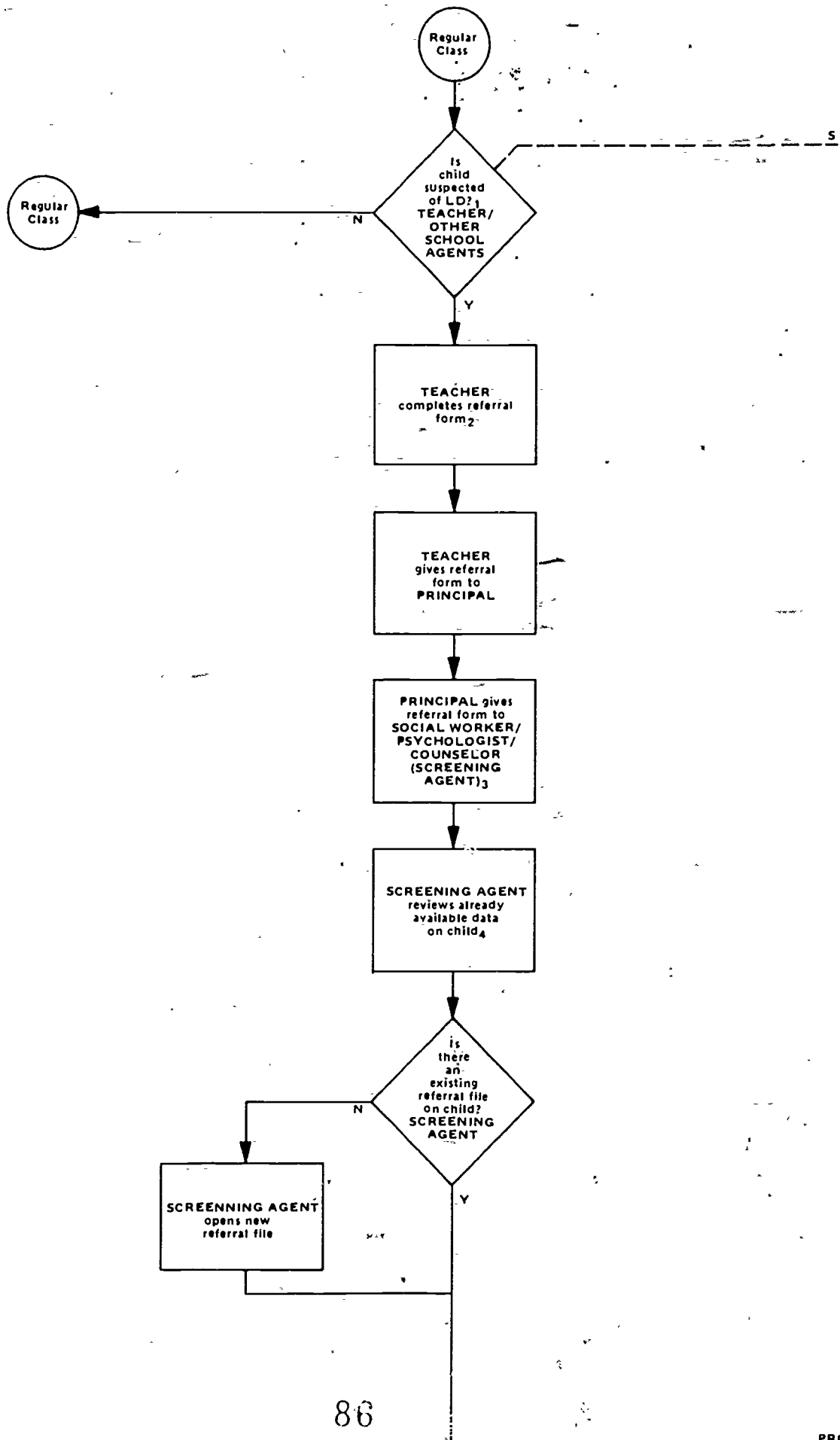
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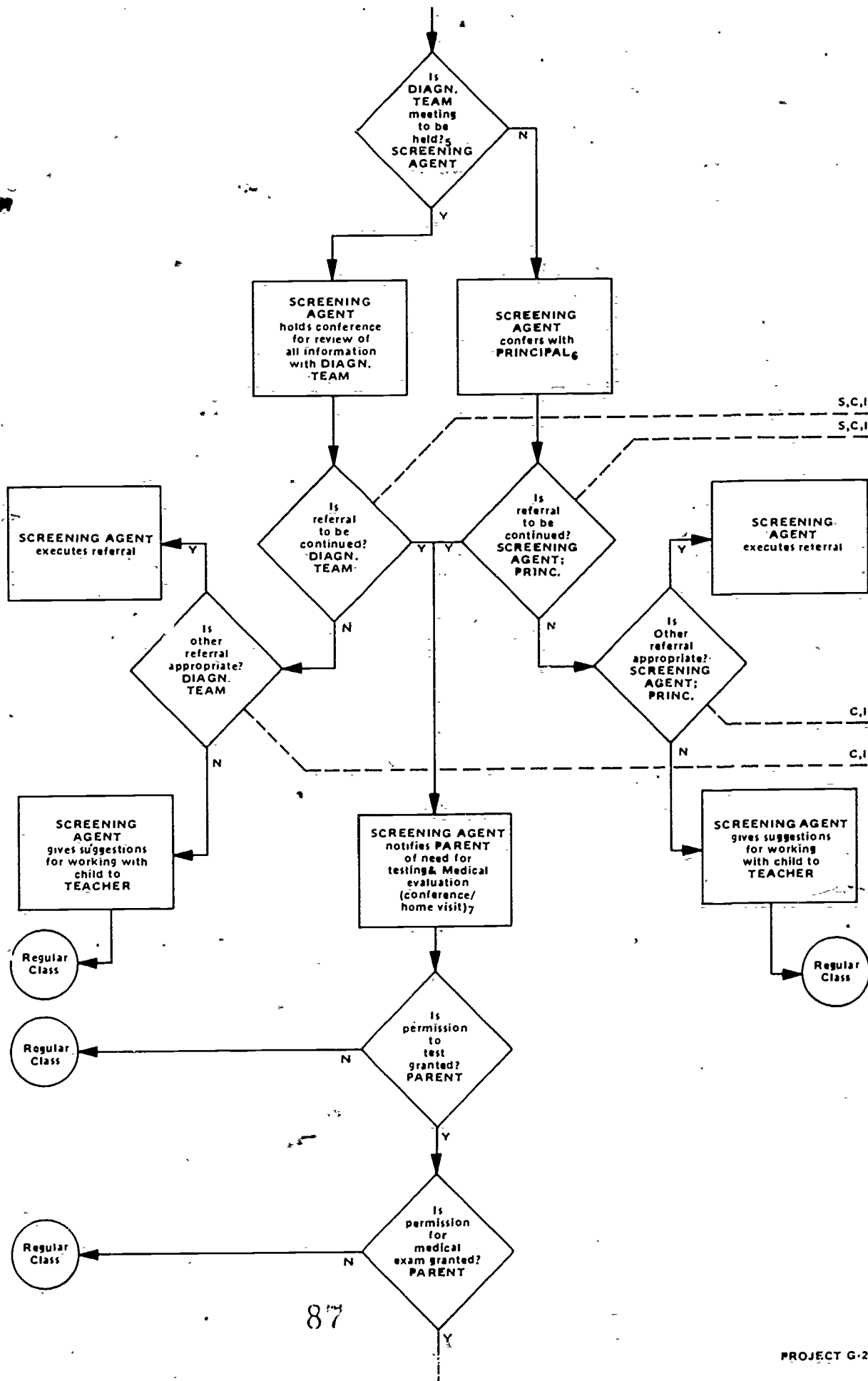
1. LD Staff consists of LD Coordinator, LD Teacher, Relief Teacher, (LD), Aide and Secretary.
2. Suspicion of LD is based on any discrepancies found in the cumulative records (e.g. IQ vs IQ; IQ vs Achievement Scores; Achievement Scores vs Achievement Scores). It should be stressed that extensive records were available to cull, i.e., several intelligence tests, achievement tests (e.g. MAT, WRAT, WISC, CMM, PPVT, SIT and Distar follow through Testing Program).
3. Behavior rating scale used is the form "A Basic Screening and Referral Form for Children with Suspected Learning and Behavioral Disabilities" by Robert E. Valett.
4. LD Screening Test is the latter portion of the Valett form noted above.
5. LD Coordinator is the Title VI-G Project Director.
6. All children who go through the system from this point on are considered as eligible for LD intervention; all testing and decision-making from this point is for purposes of programming, not identification.
7. LD Coordinator decides which 32 children will be included for special help. There was heavy reliance on the ITPA in making these decisions; Also, was the child both referred and picked up by the records. The LD Resource Room is one in which LD children are taken as a group from their Regular Classrooms for periods up to two weeks at a time. For these periods it might be considered as a Self-Contained LD Room,

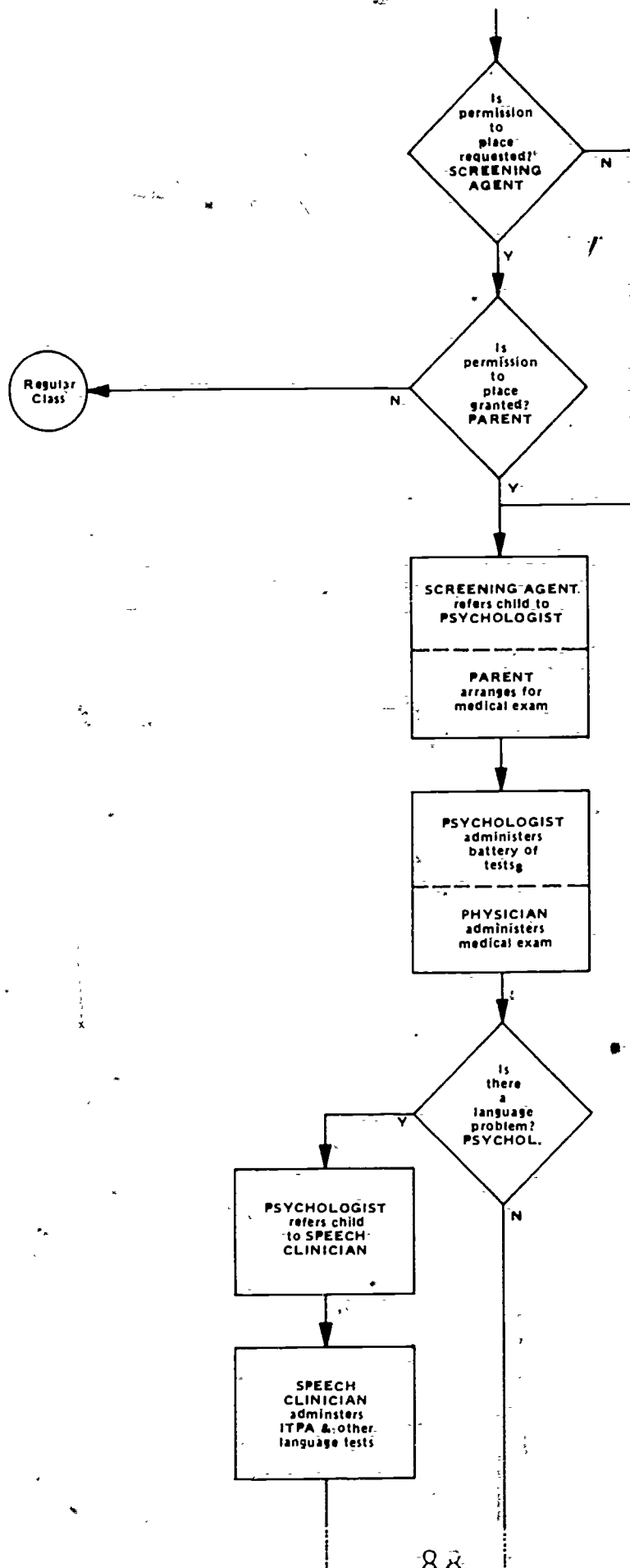
but since this is temporary and the children return shortly to their regular classes, we have classified this system as an LD Resource Room.

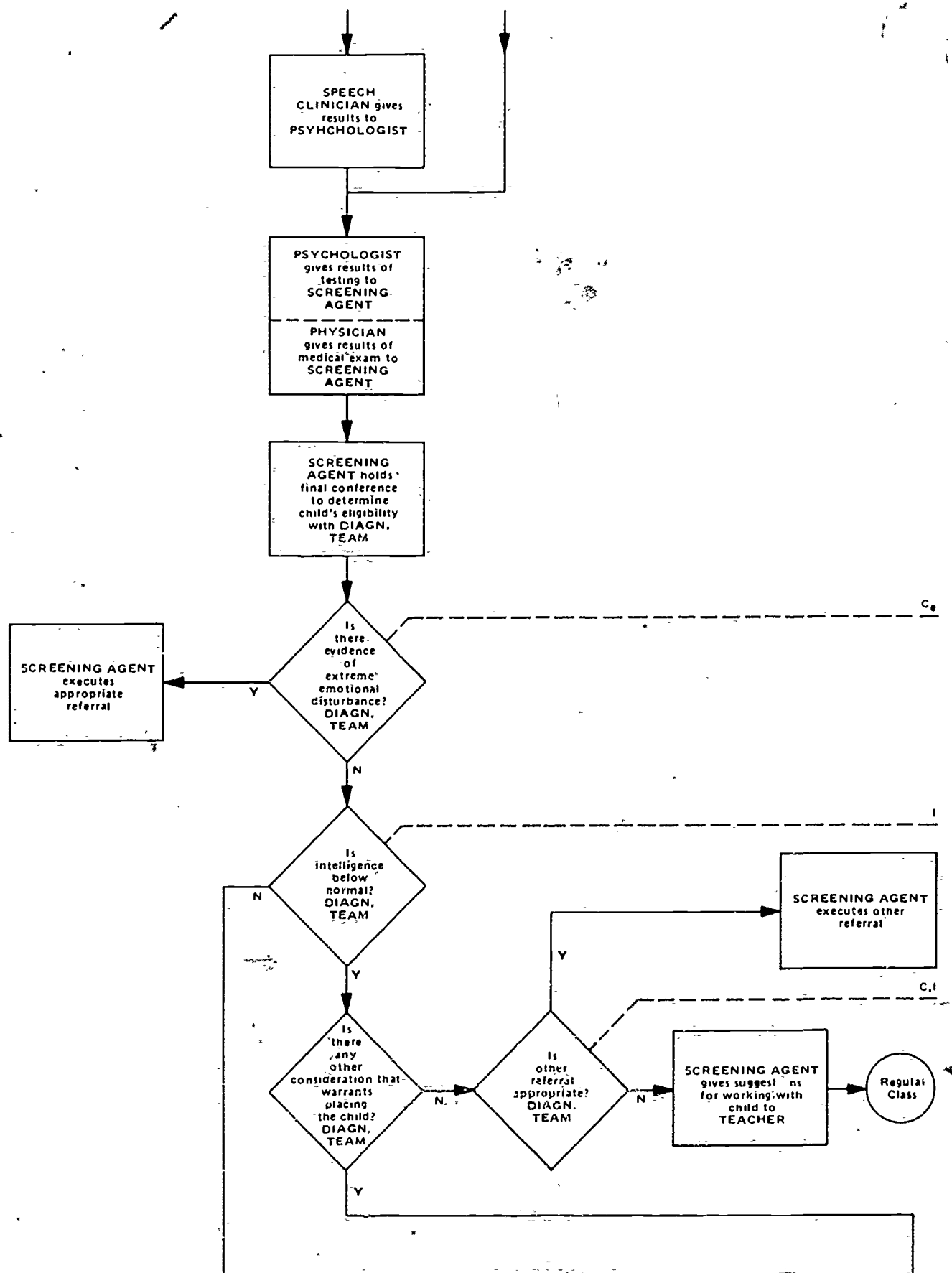
8. The waiting list was 25 or 30 children considered "questionable LD".
9. No parent refused placement.
10. Diagnostic tests given include PIAT, Frostig, Key-Math, Durrell, Purdue, Boehm, Wepman, Bender, Fitzhugh, WISC.

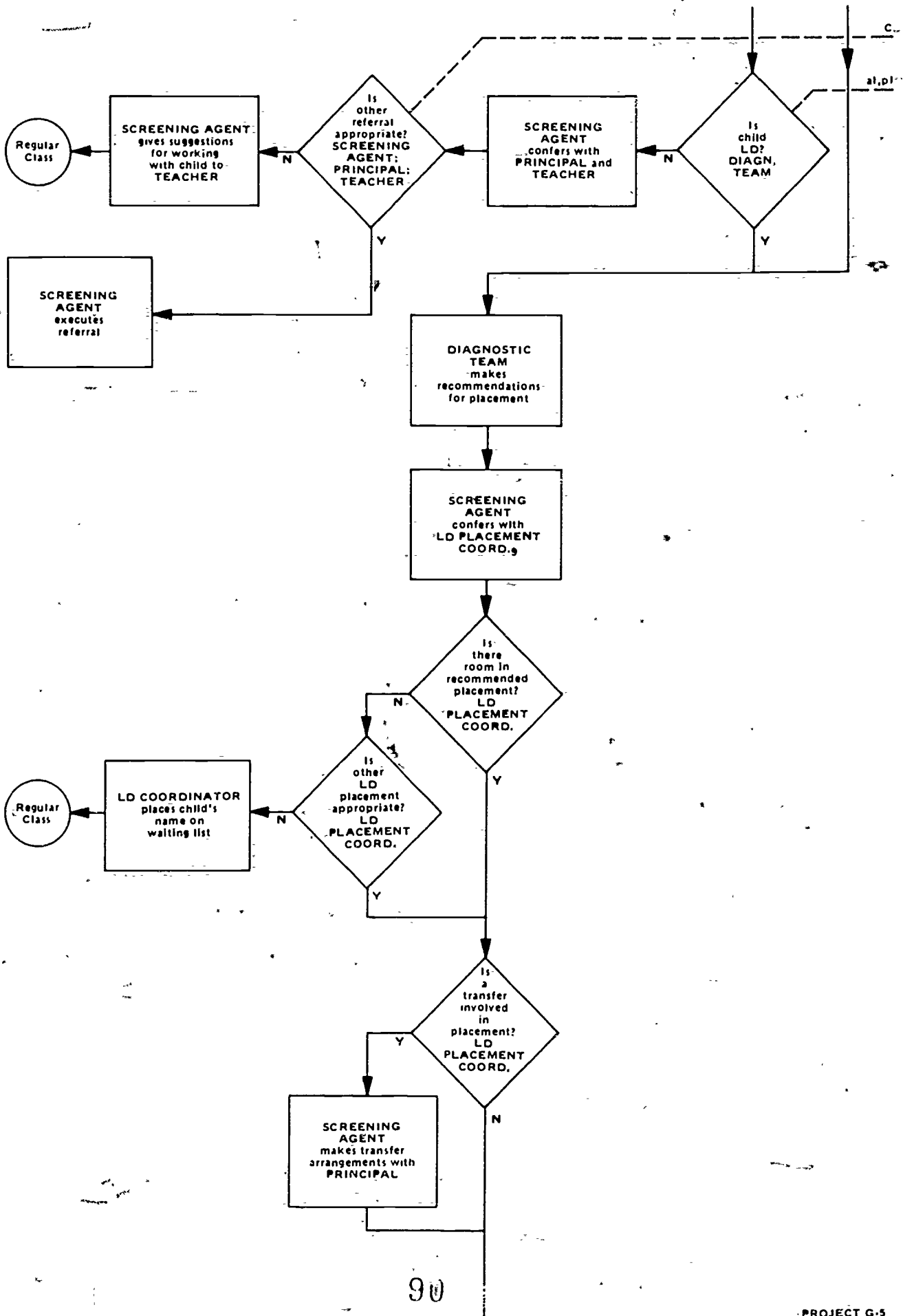
Project F-5

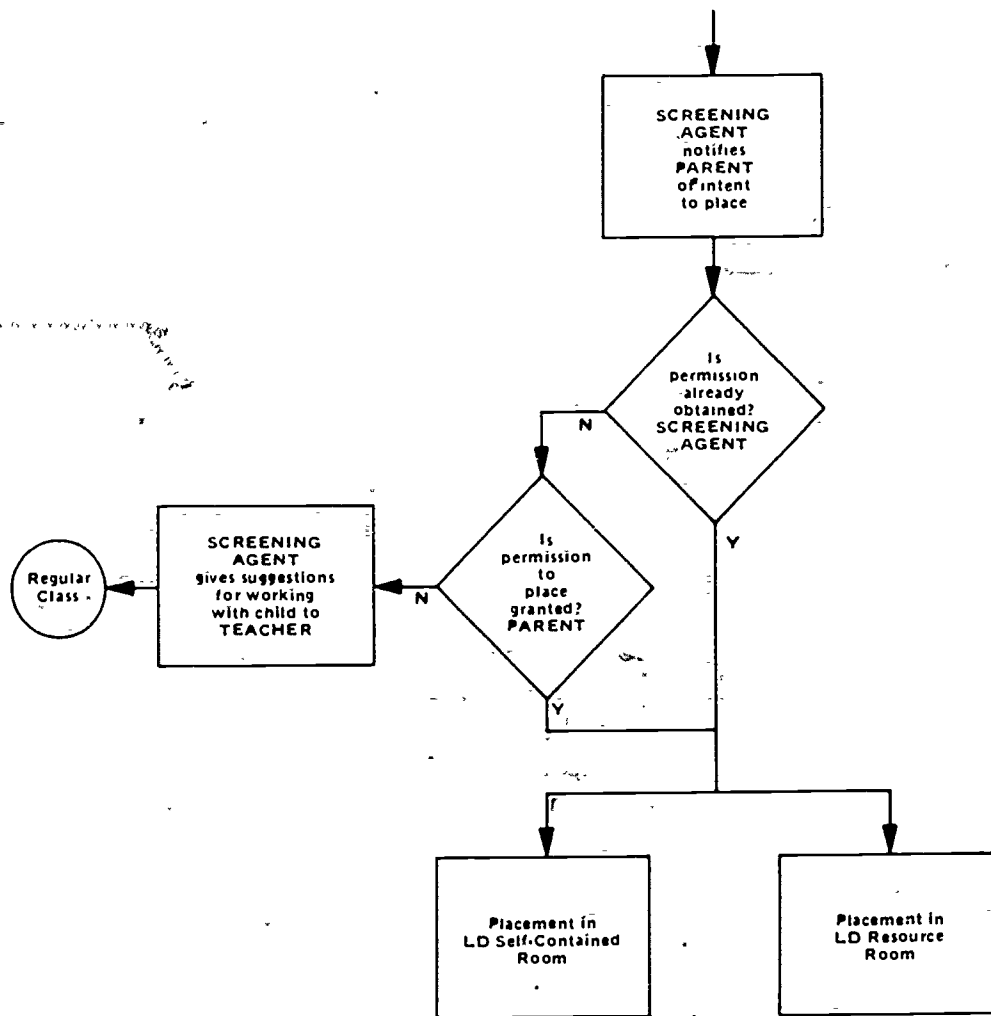












I. GENERAL INFORMATION

1. Project Code Letter: G
2. Delivery System for Intervention: LD Self-Contained (Grades K-12)
LD Resource Room
3. Initial Entry: Referral (Teacher/other School Agents)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Other School Agents
Screening Agent
Principal
Diagnostic Team (Principal, Teacher, School Nurse
or Physician, LD Teacher,
Psychologist, Speech Clinician -
optional)
 - b) Constraining decisions: Screening Agent
Parent
Psychologist
LD Placement Coordinator

II. SPECIAL NOTATIONS

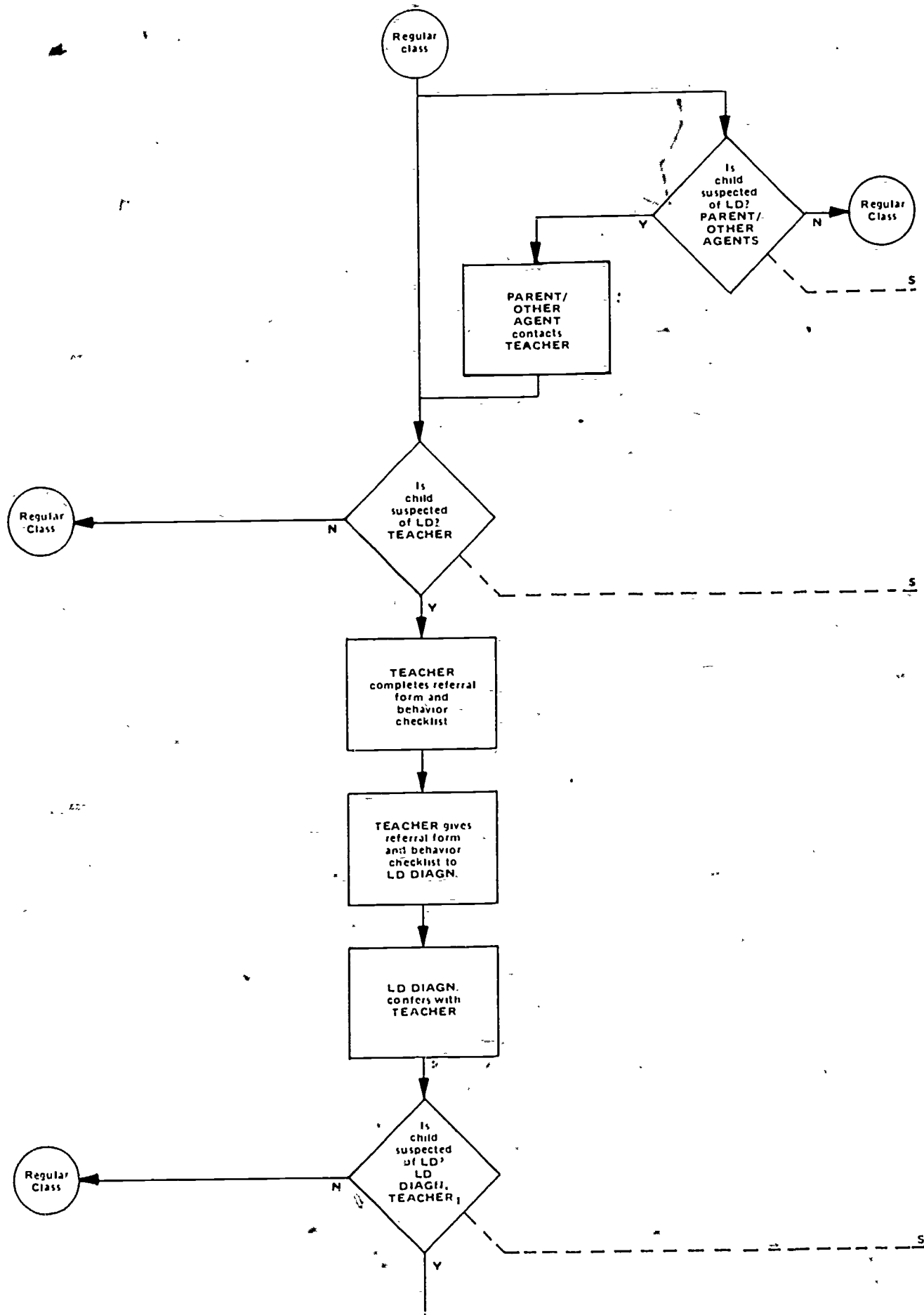
(footnotes apply to notations on flow-chart)

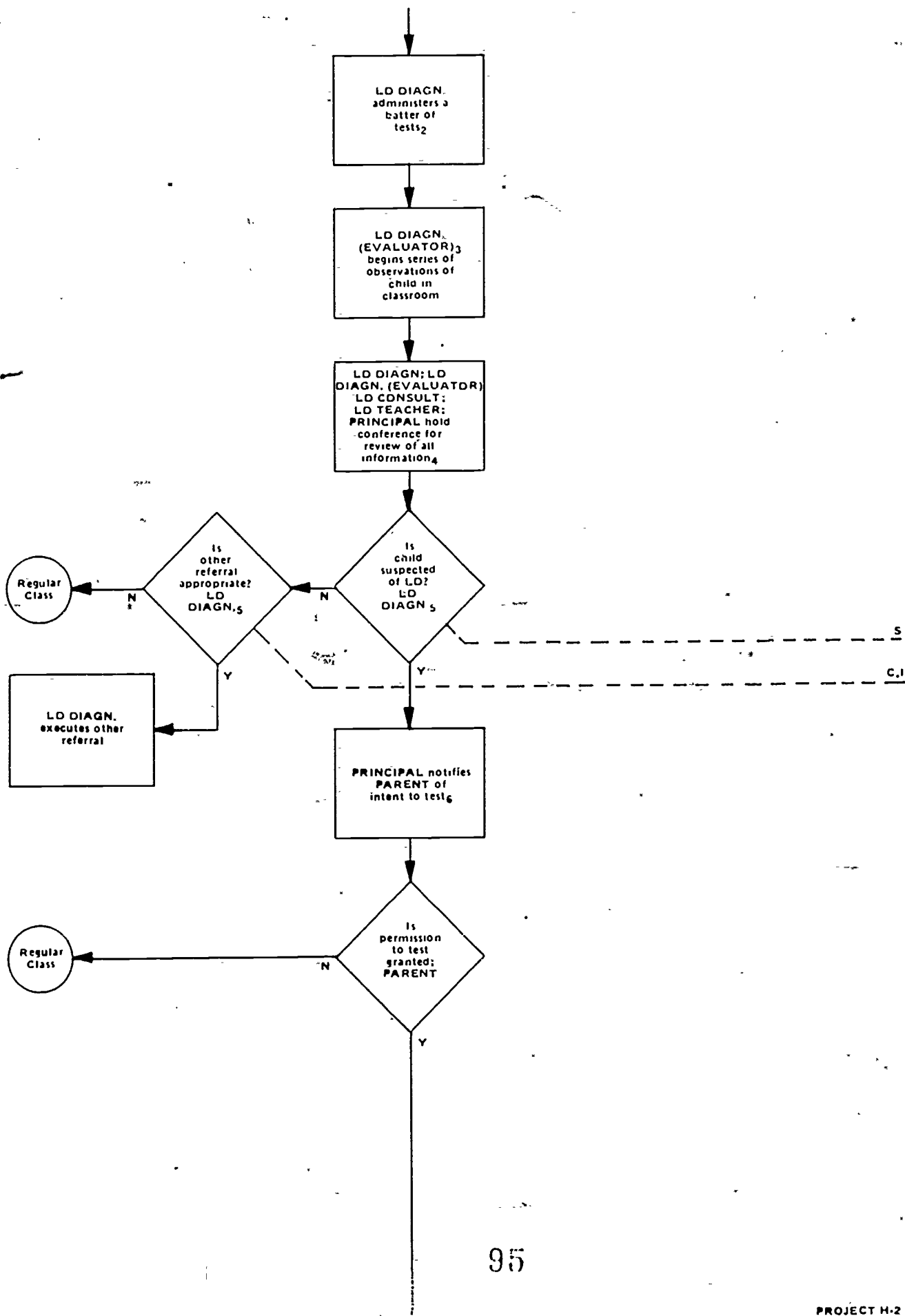
1. In this project, the LD category and the ED or BD category are combined into the Educationally Handicapped (EH) classification. Therefore, throughout the chart, please note that the term LD designates this more inclusive category. In this system the decision as to primary emotional problems (C_e) is based on the existence of extreme emotional disturbance (i.e., psychosis) while in pure LD classification systems a child might be eliminated for less severe problems in this area.
2. There is considerable variation in the degree of specificity and completeness with which a teacher completes the form, depending on standards set by screening agent.
3. The District Pupil Personnel Director decides who serves as Screening Agent in each school. Principals prefer (and may request) counselors, since they can be used as teacher substitutes.
4. Data includes: a) review of cumulative record; b) review of health record (particularly vision and hearing); c) observation of child; d) conferring with teacher and other personnel; e) collection of samples of child's work.
5. Although specific persons are specified on paper as belonging to this team, there appears to be considerable flexibility among schools. Those specified

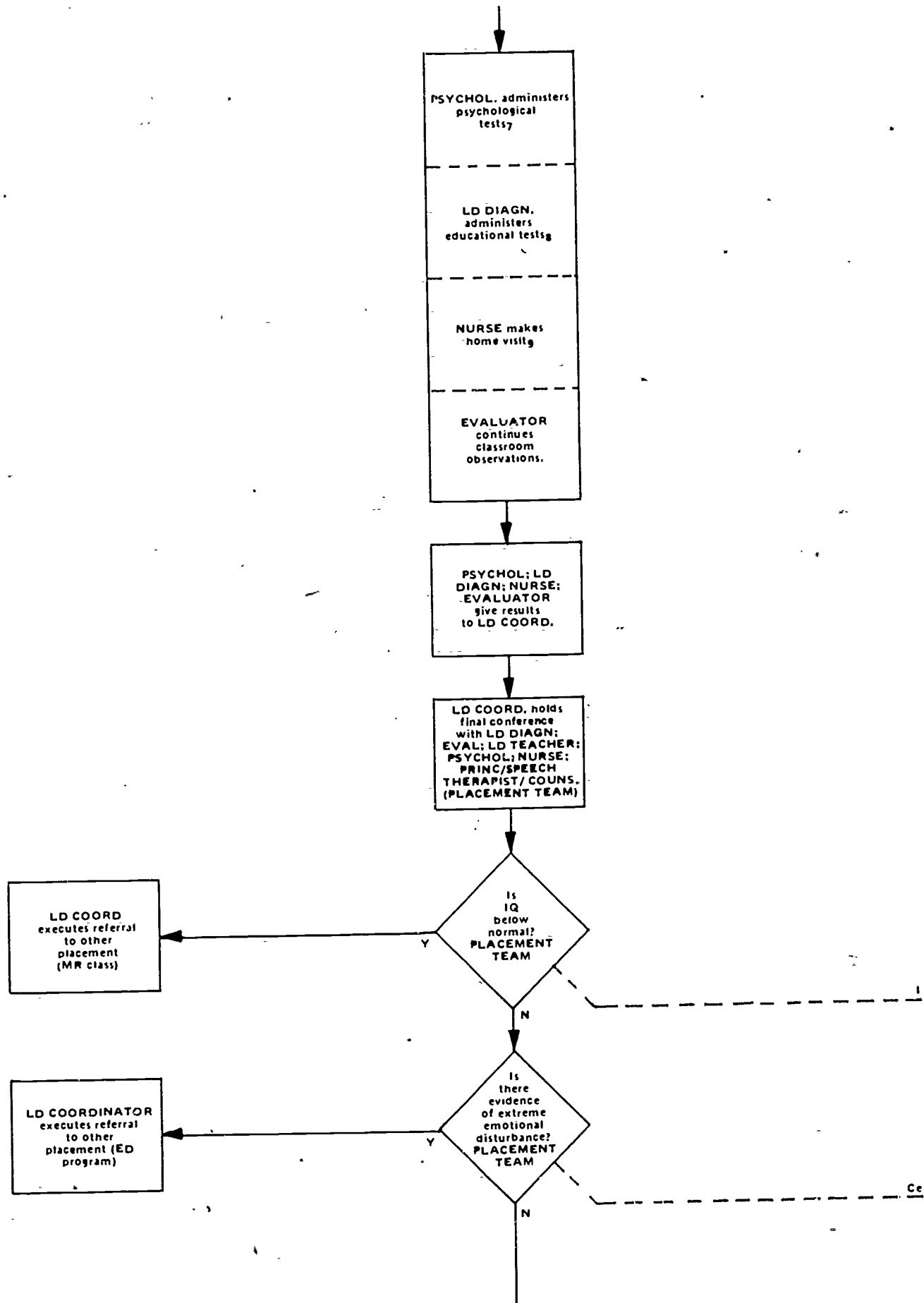
Project G-7

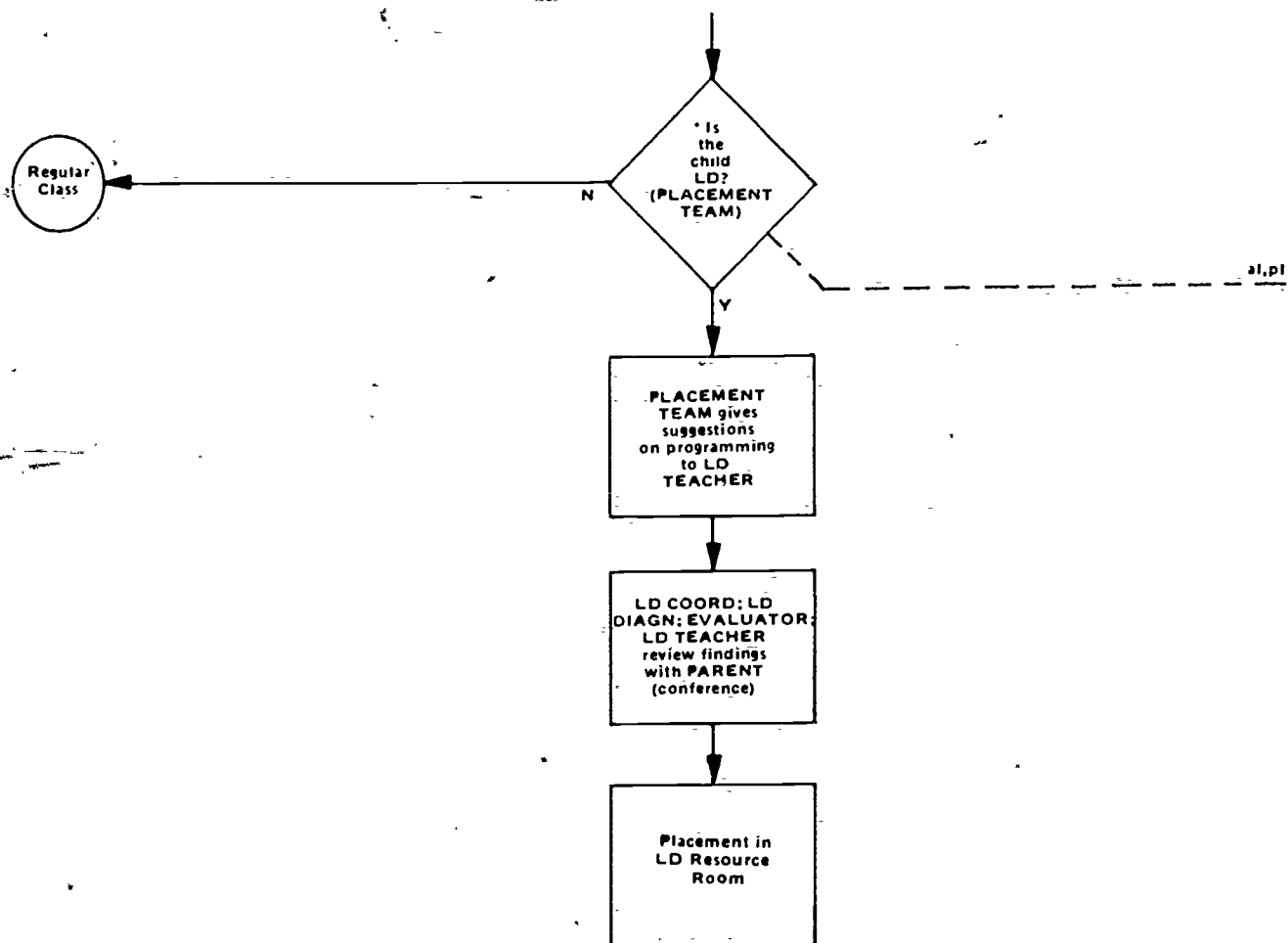
include Principal, Teacher, School Nurse or Physician, LD Teacher, Psychologist; Speech Clinician is optional and is included if there appears to be a language disability.

6. This initial meeting to review information on a child is optional. Many Screening Agents simply decide about continuing the referral in conference with the principal.
7. If EH placement is a possibility, the child must be evaluated by a physician as to neurological or emotional handicap, and this medical report is included as part. During the conference or home visit, the Screening Agent also gathers social and developmental information.
8. Some individual IQ test is required (WISC, Binet, WAIS, etc.). Other tests are optional and may include Bender, WRAT, Draw-a-Person, Rorschach, CAT, Sentence Completion Test, Wepman. Testing covers these areas: intelligence, academic achievement, visual motor skills, personality.
9. The role of LD Placement Coordinator is exclusively concerned with placing children who have been identified for service. This person does have the power to shift a child from the recommended LD placement to another LD placement if the former is presently unavailable.









I. GENERAL INFORMATION

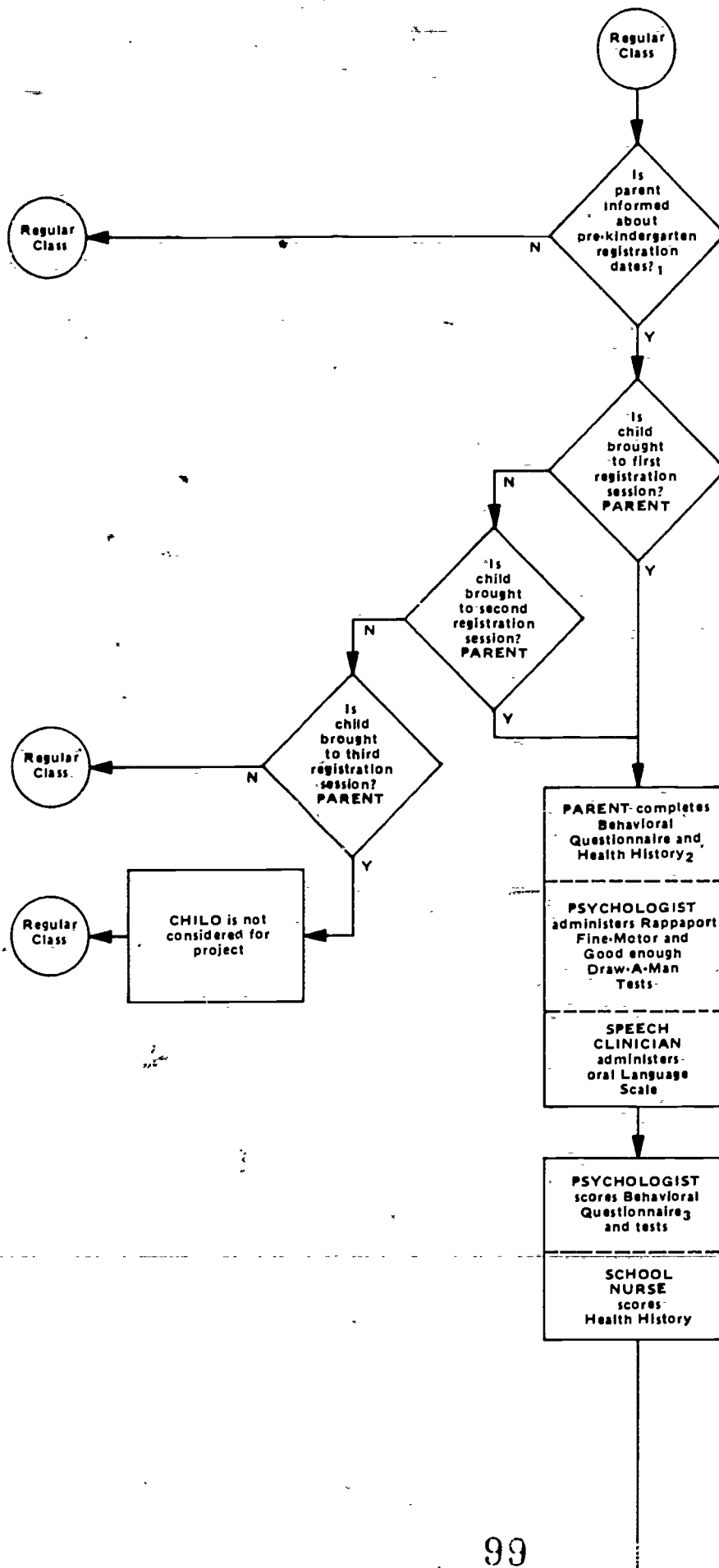
1. Project Code Letter: H
2. Delivery System for Intervention: LD Resource Room (Grades 1-6)
3. Initial Entry: Referral (Teacher/Parent/other Agents)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Parent
LD Diagnostician
 - b) Constraining decisions: Parent

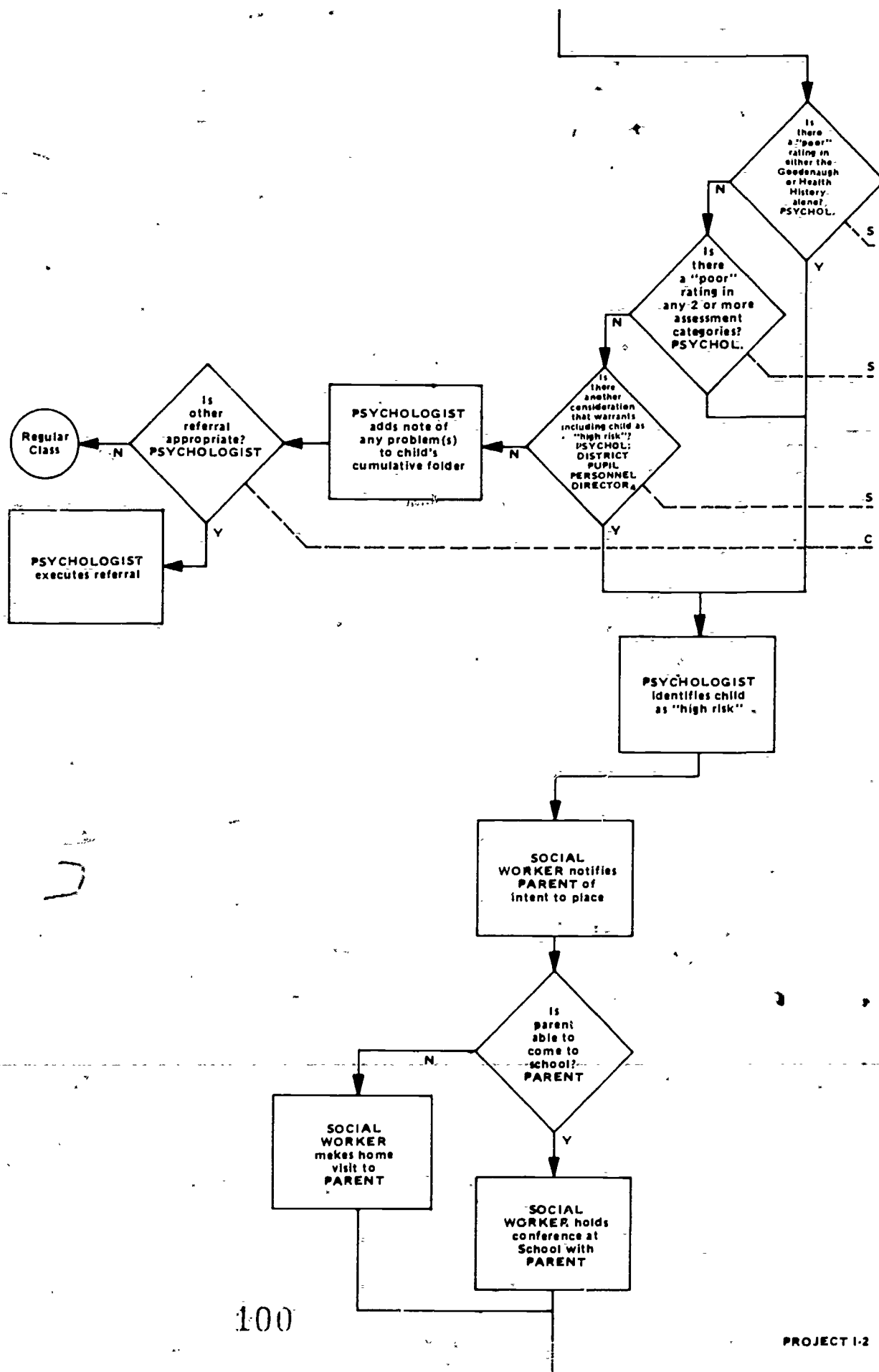
II. SPECIAL NOTATIONS

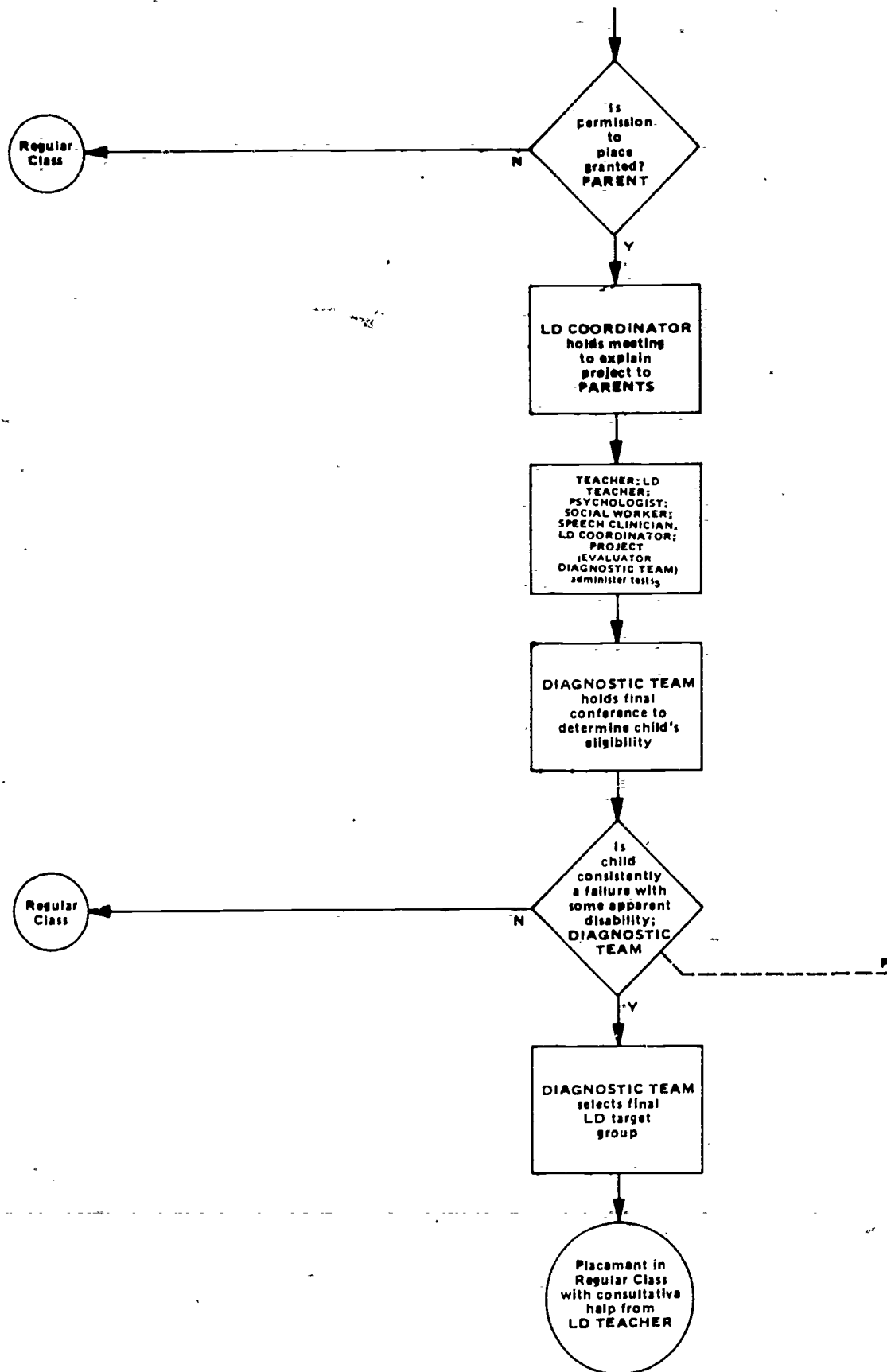
(footnotes apply to notations on flow-chart)

1. Due to three years of in-service the teachers and LD Diagnostician rarely disagree at this point.
2. Battery of tests consists of SIT, PPVT, WRAT, Wepman, VMI, Bender. These are designated as "screening tests."
3. LD Diagnostician (Evaluator) is a specific member of the Diagnostic Team; his role is essentially to observe and record behavior of children in the classroom during the period of diagnostic evaluation and after children have been placed in intervention.
4. Principal has no input to the decision-making; he is included in conference for purposes of keeping him informed.
5. Although the LD Diagnostician essentially makes this decision, based on results from the test battery, the Evaluator and other LD staff submit input.
6. Permission slip is sent home with child.
7. Psychologist gives WISC; Draw-A-Person.
8. LD Diagnostician gives Detroit, CAT, ITPA, "Lindennode" Auditory Conceptualization test, PSLT.
9. Nurse's home visit is to gather family information.

Project H-5







I. GENERAL INFORMATION

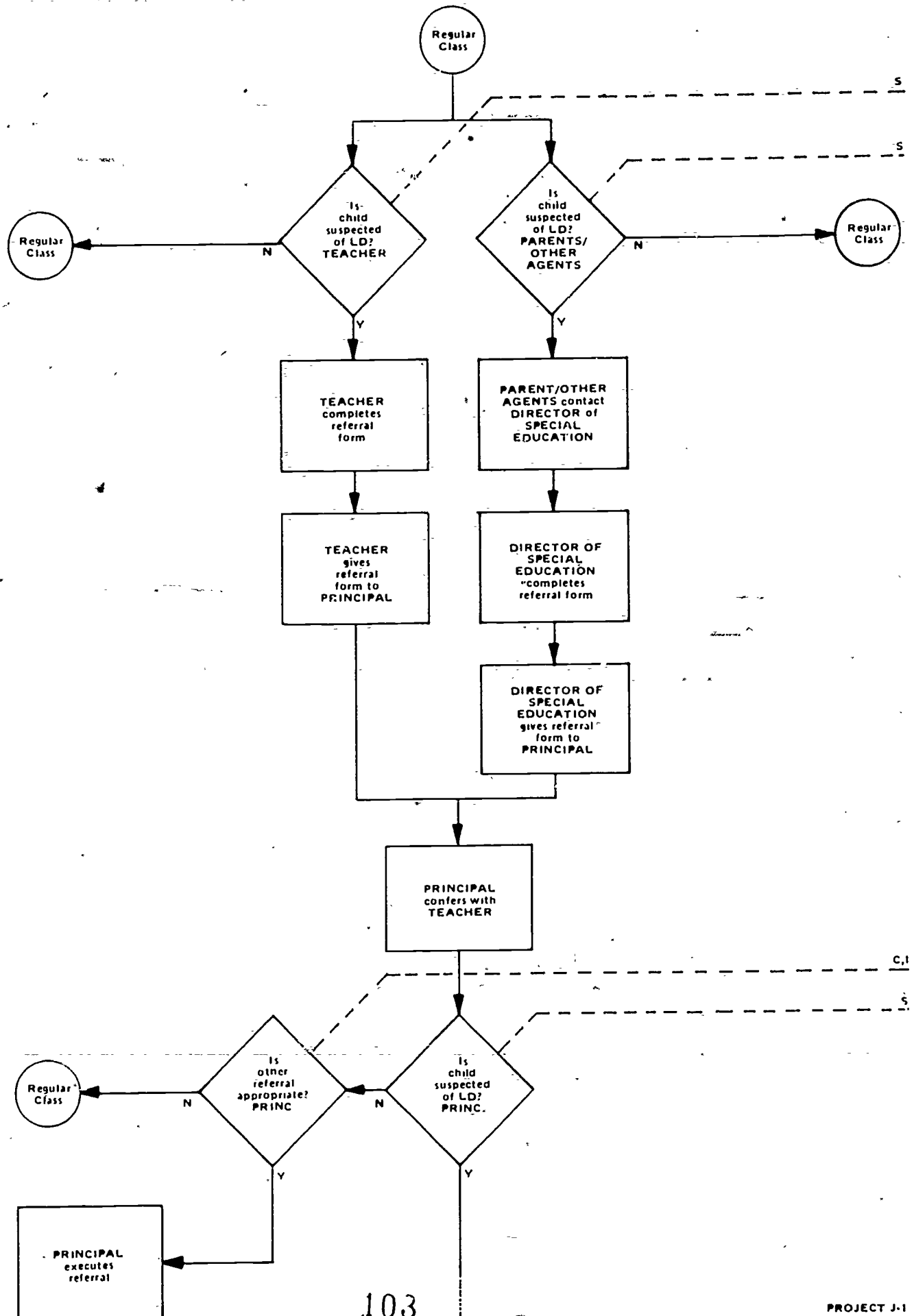
1. Project Code Letter: I
2. Delivery System for Intervention: LD Consultative (Kindergarten)
3. Initial Entry: Mass Screening (Goodenough-Harris Draw-A-Man Test; Rappaport Fine Motor Test; Oral Language Scale; Health History; Behavioral Questionnaire)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Psychologist
District Pupil Personnel Director
 - b) Constraining decisions: Parent

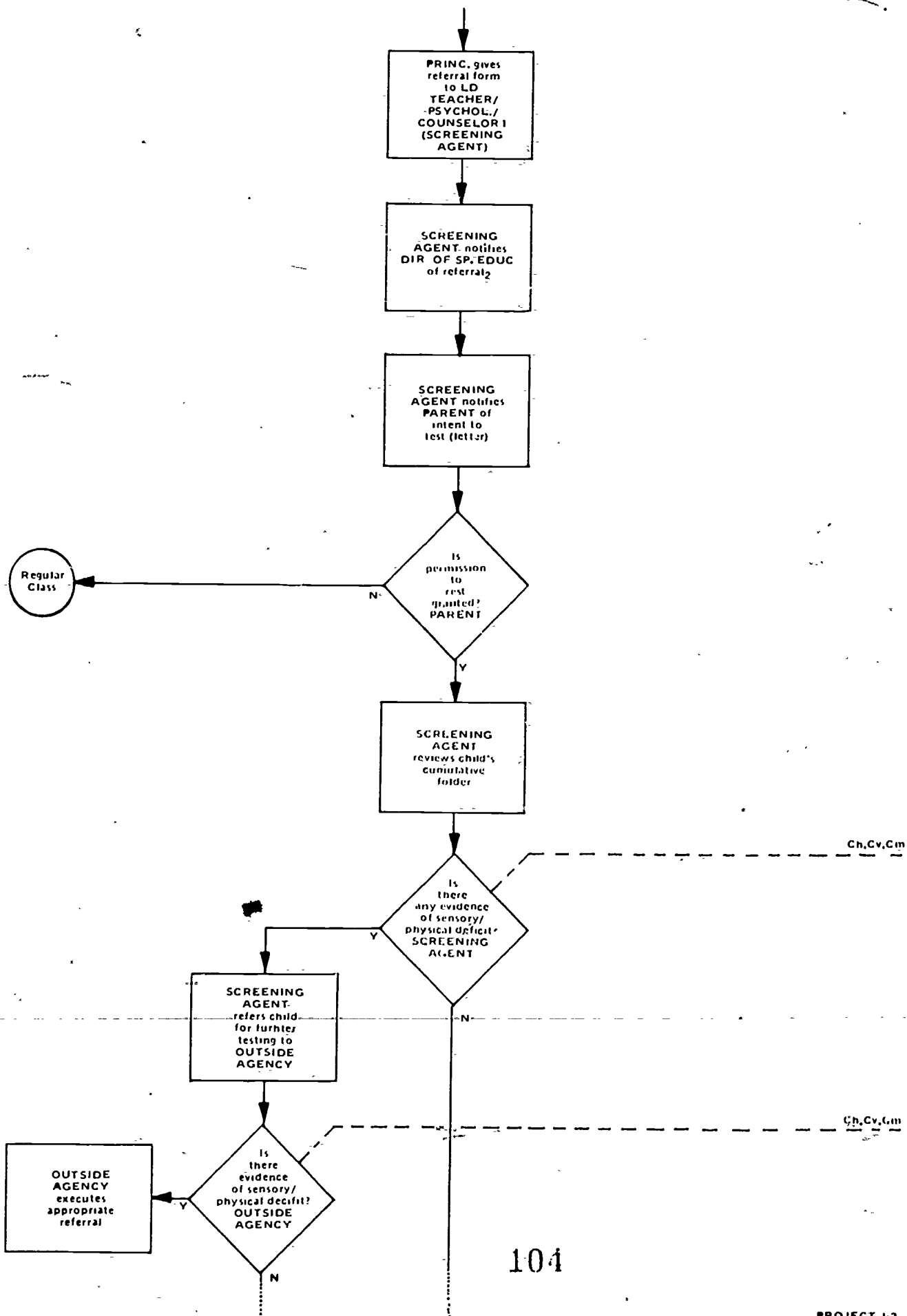
II. SPECIAL NOTATIONS

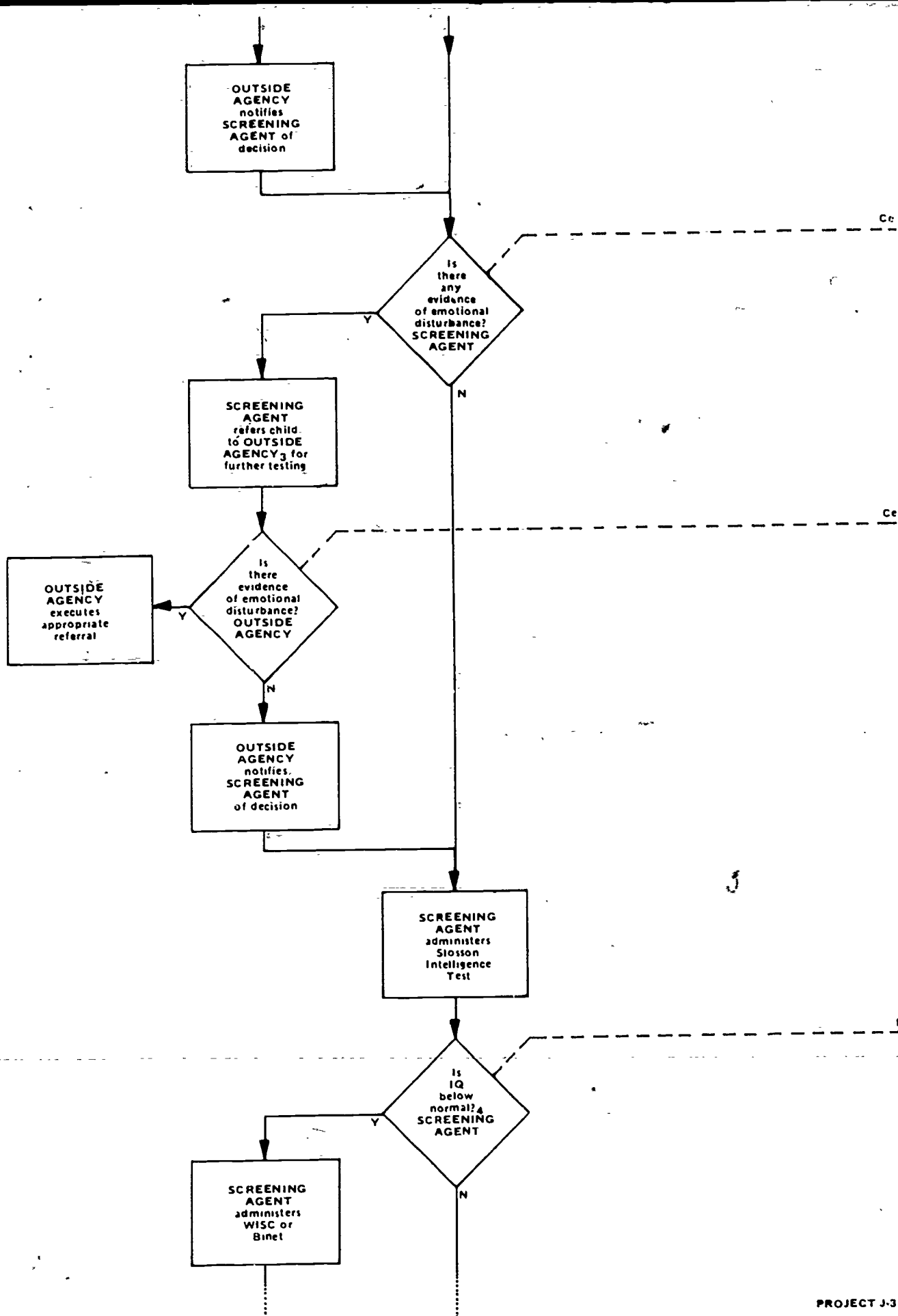
(footnotes apply to notations on Flow-Chart)

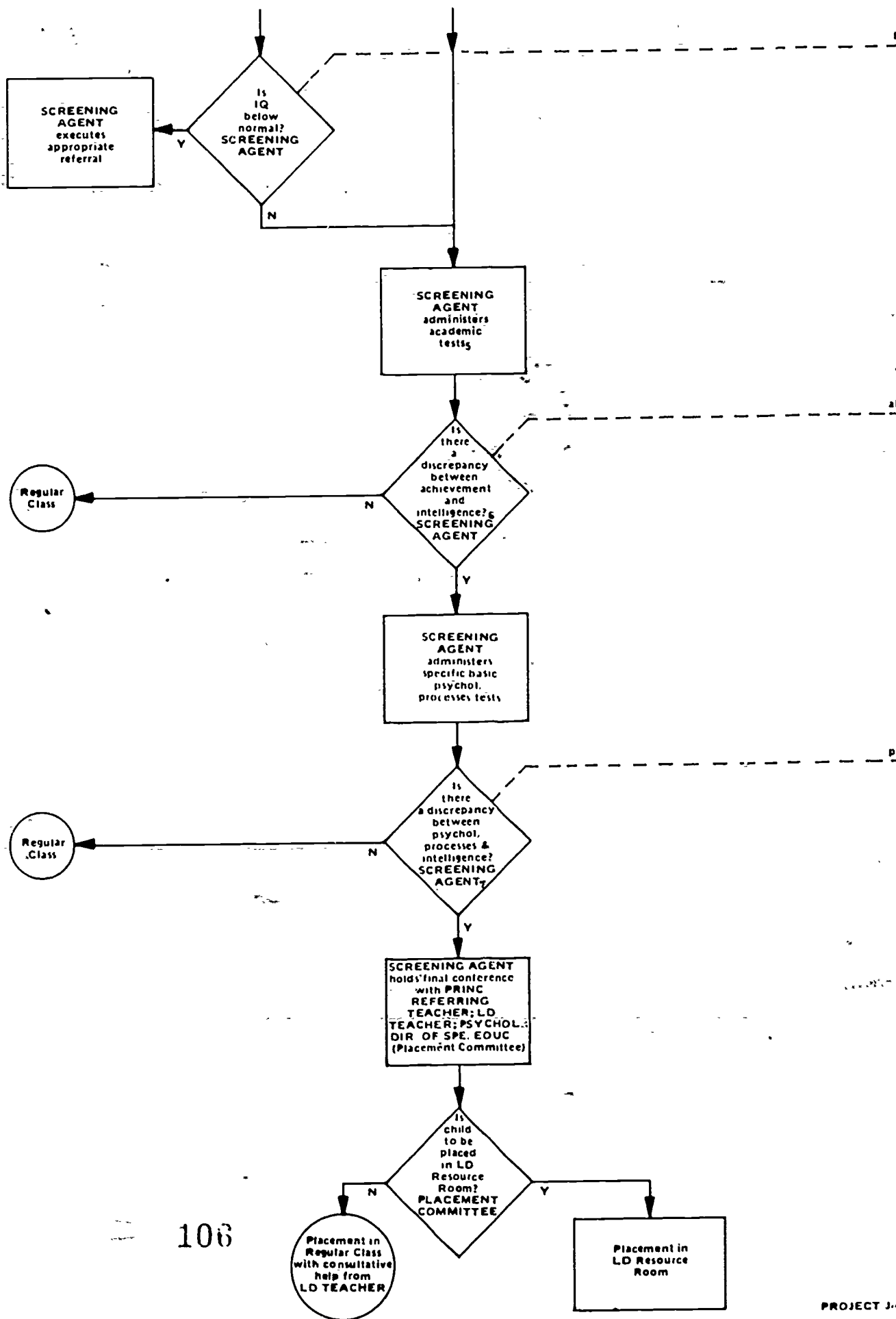
1. Parents were notified by newspaper articles and letters from the PTA; 1st registration is April; 2nd registration is June; 3rd registration is August.
2. Student nurses from a local nursing school help parent complete Behavioral Questionnaire; Health History form is completed with the School Nurse.
3. Prior to scoring of instruments, the Director of Special Education and District Pupil Personnel Director weighed all items on Behavioral Questionnaire.
4. Only in cases where there is a question, does Psychologist consult the District Pupil Personnel Director.
5. This takes place in a 4 week summer diagnostic session, with children randomly divided into a task analysis group (teachers; LD teacher; psychologist; social worker; speech clinician; Project evaluator; LD Coordinator.) In the task analysis group, data for evaluation (diagnosis) was gathered by using diagnostic tasks with the children. In the multi-disciplinary group, the team members administered various tests for evaluation (diagnostic) purposes. Tests covered psychological, educational, sensory, and medical (if needed) appraisal.

Project I-4









I. GENERAL INFORMATION

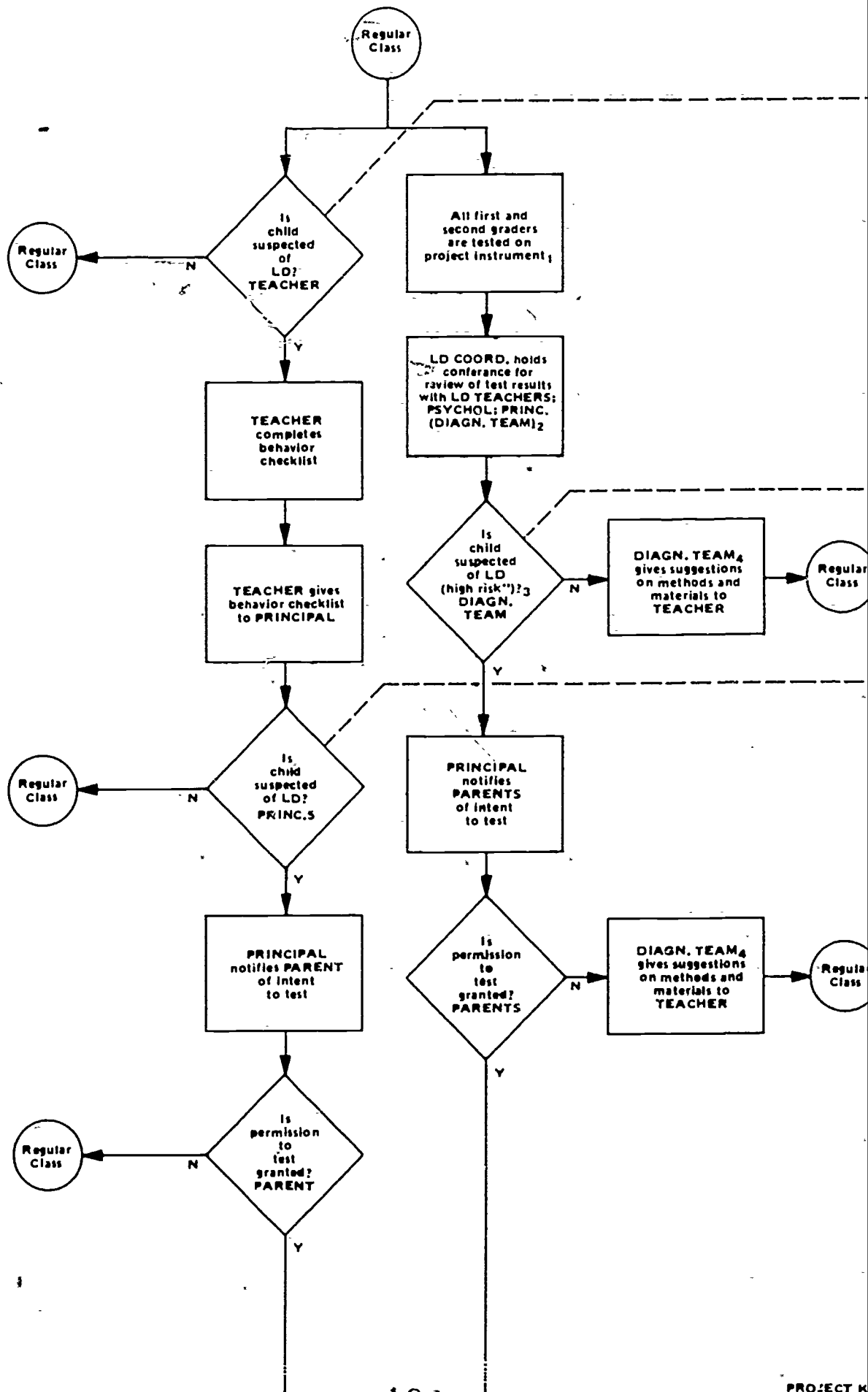
1. Project Code Letter: J
2. Delivery System for Intervention: LD Resource Room; Consultative (Grades K-8)
3. Initial Entry: Referral (Teacher/Parent/Other Agents)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parents Screening Agent (LD teacher/
Other Agents Psychologist/Counselor)
Teacher Outside Agency
Principal Placement Committee (Principal;
referring teacher; LD Teacher;
Director of Special Education)
 - b) Constraining decisions: Parent
Placement Committee

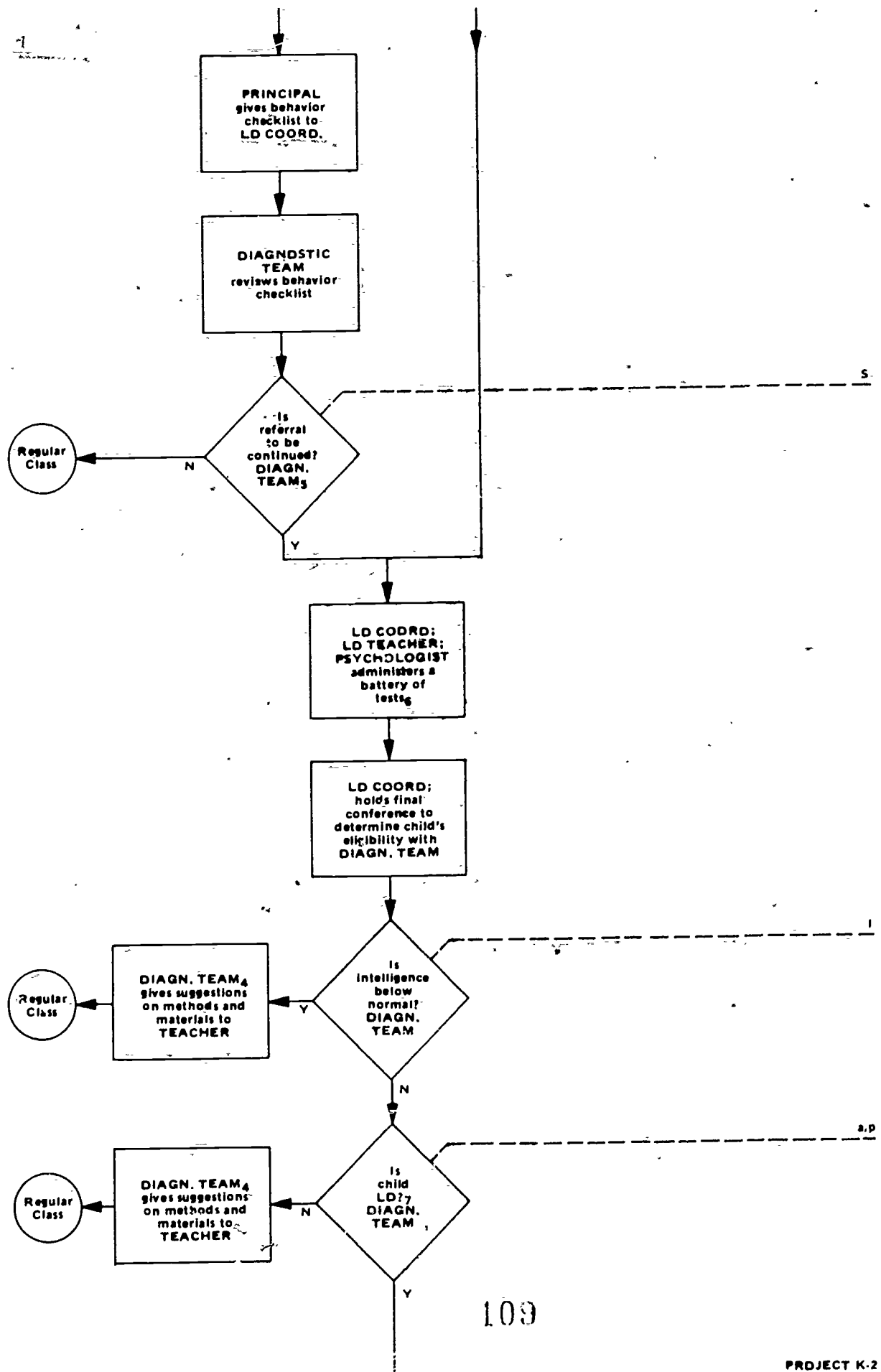
II. SPECIAL NOTATIONS

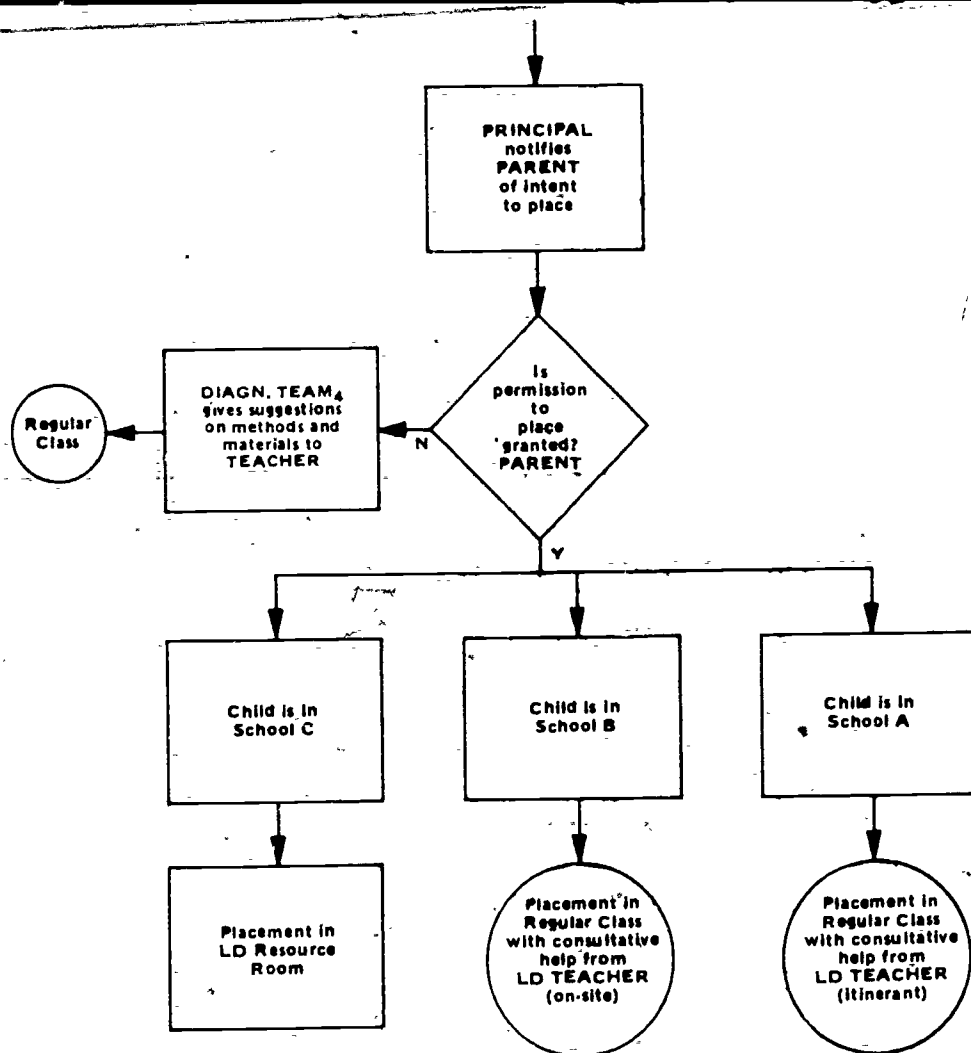
(footnotes apply to notations on Flow-Chart)

1. The person responsible for the referral from this point on ("Screening Agent") varies among school districts, and sometimes among schools within a district. It is also possible that the person designated as responsible may request that some step be completed by someone else. Precise information regarding these variations is not available, except where noted.
2. This is strictly an administrative procedure, so that the District Special Education Office is kept informed of referral patterns.
3. This may simply be a referral with the school building; it is "outside" in the sense that it is not done by the Screening Agent.
4. "Below normal" is defined as 70 or below.
5. Includes PIAT: WRAT. Covers areas of reading; writing; arithmetic; spelling; pre-academic skills.
6. The child must be in lowest 10th percentile in at least one area, as based on his Expectancy Age (i.e., formula developed by Harris (1971): $\frac{2MA + CA}{3}$).
7. The child must demonstrate a discrepancy of -2 standard deviations in at least one area as based on his Expectancy Age.

Project J-5







I. GENERAL INFORMATION

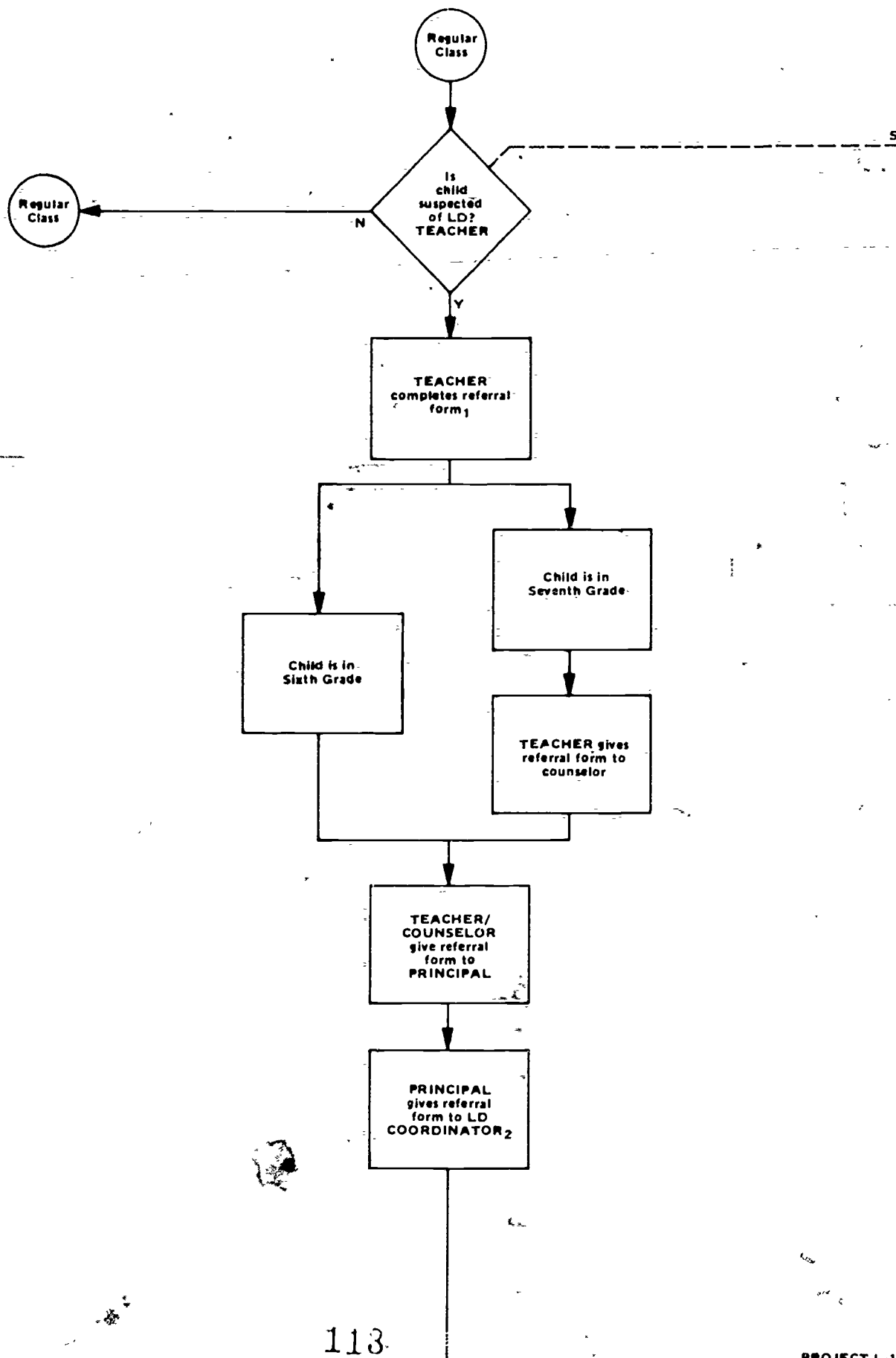
1. Project Code Letter: K
2. Delivery System for Intervention: LD Consultative (on site & itinerant)
LD Resource Room (Grades 1-6)
3. Initial Entry: Referral (Teacher)
Mass Screening (locally developed test)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Diagnostic Team (LD Coordinator, LD Teachers,
Psychologist, Principal)
Principal
 - b) Constraining decisions: Parents

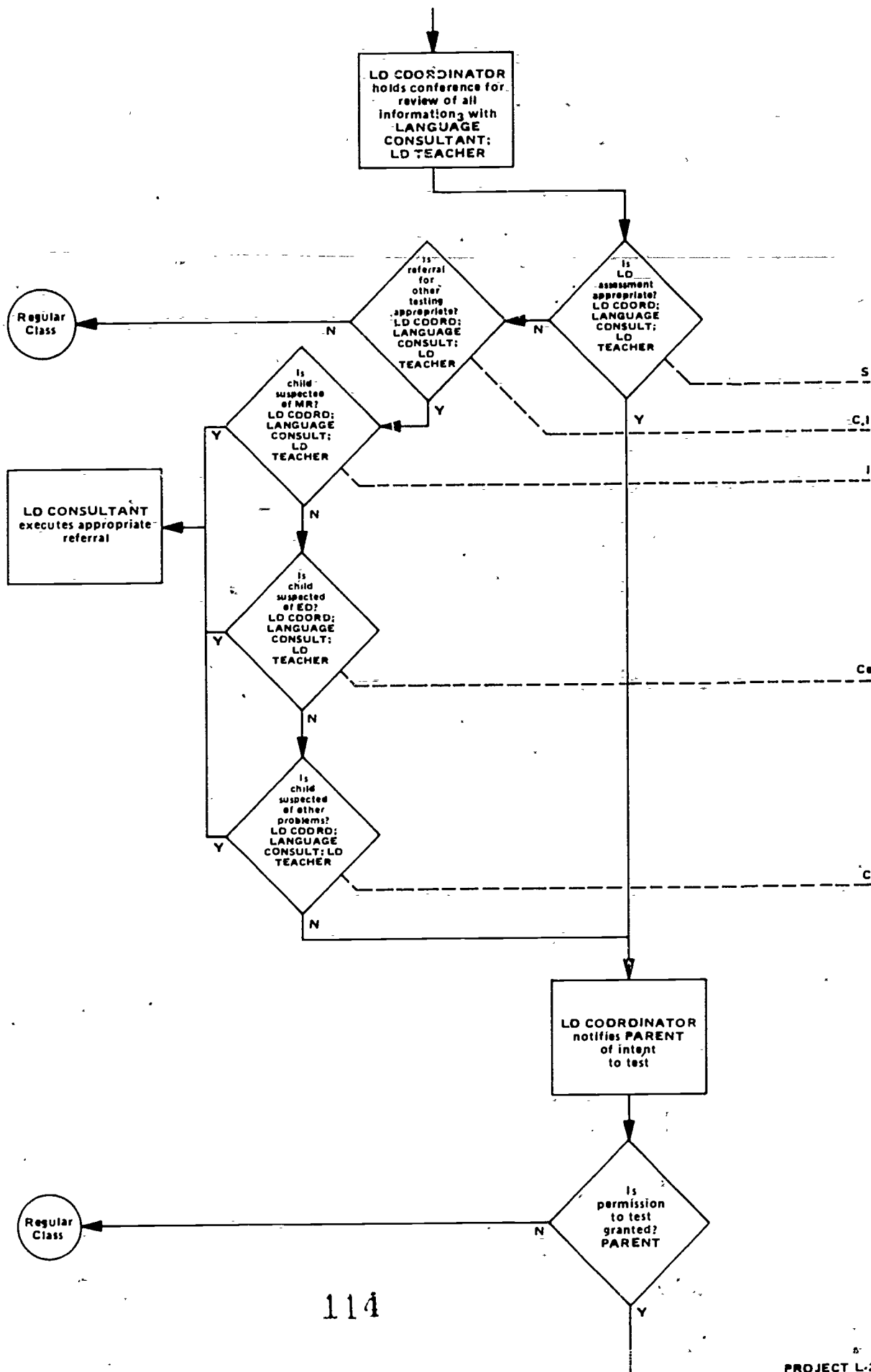
II. SPECIAL NOTATIONS

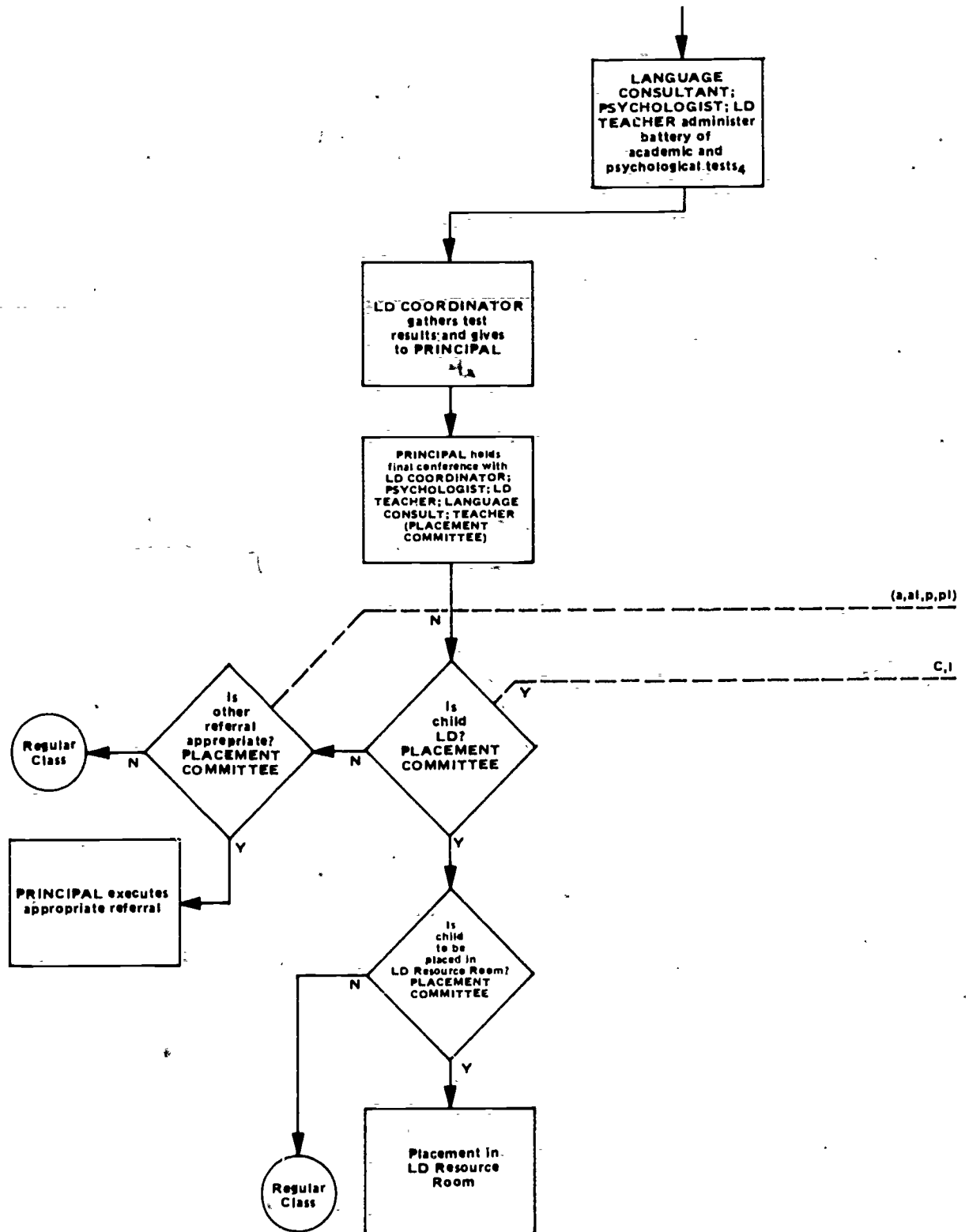
(footnotes apply on notations on flow-chart)

1. No information is available as to who administers this instrument, which was developed by the Title VI-G staff. Apparently its content is borrowed from other instruments, some of them standardized. No copy is currently available for our study.
2. The Title VI-G staff consists of an LD Coordinator, a Psychologist, and a LD teacher. When this staff meets with the Principal and LD teacher from the child's building, the total group is designated in the charts as the Diagnostic Team.
3. The criteria used are apparently quite flexible.
4. There is inadequate information to ascertain whether the entire team or selected individuals from the team provide this. Most probably, this is the responsibility of the LD teacher.
5. It is very unusual for a child to be eliminated at this point, but it can happen.
6. Psychological tests include WISC, Bender, Draw-A-Man, with additional perceptual motor tests for younger children.
Auditory tests include Audiometer, subtest of ITPA, and Wepman.
Visual tests include Snellen, Telebinocular.
Educational tests include WRAT, BESSE, IRI, and specific criterion-reference tests.
Language tests include the Utah Language Development Scale.
In addition, measures of health and social behaviors are made, although specific instruments are not designated.

7. The criteria at this point include a deficit in some basic psychological process, and an academic deficit of 2 years. It is unclear whether the child must meet both criteria, although it appears likely that the Team is flexible on this.







I. GENERAL INFORMATION

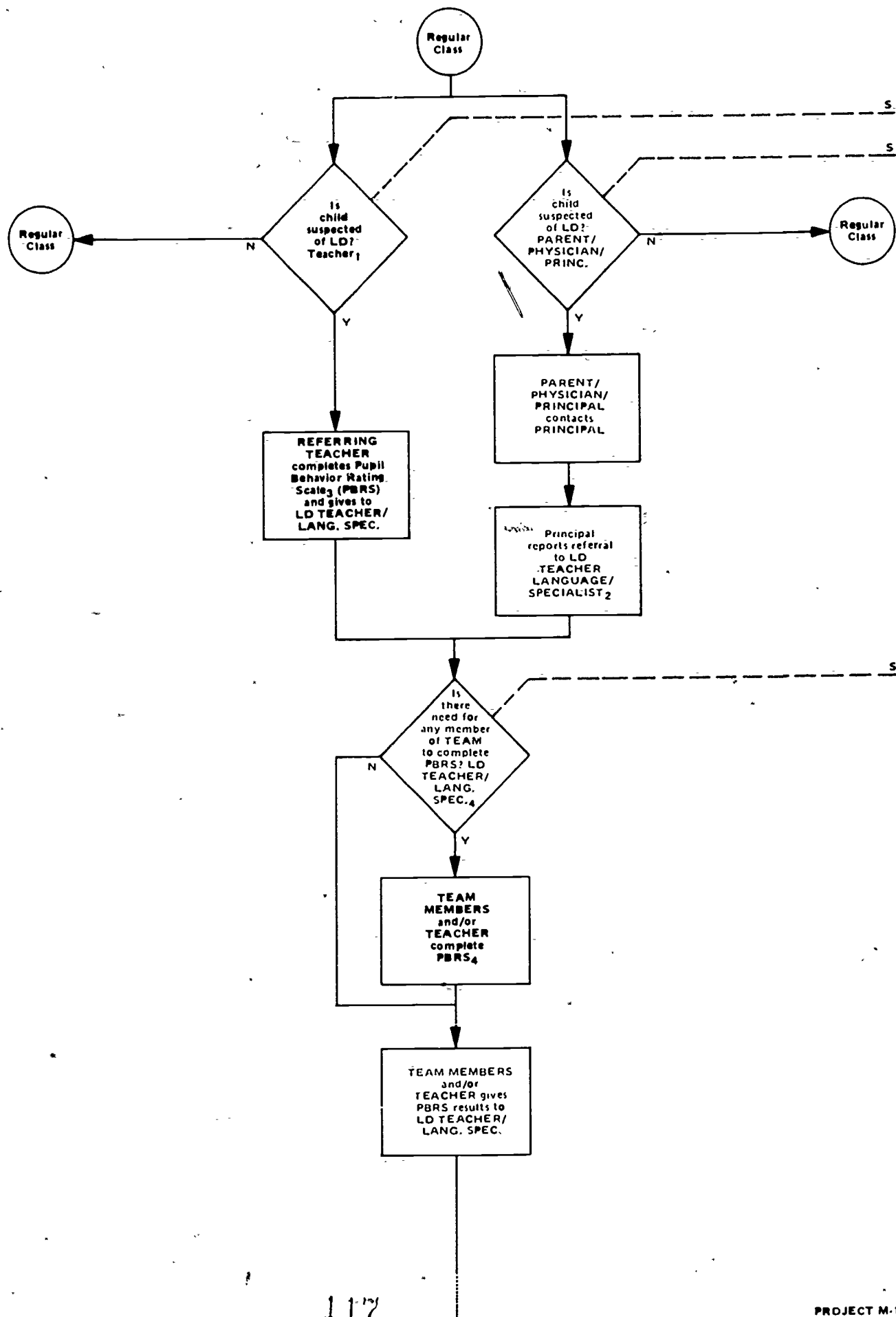
1. Project Code Letter: L
2. Delivery System for Intervention: LD Resource Room; (Grades 6-7)
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher LD Teacher
LD Coordinator Psychologist
Language Consultant Principal
 - b/) Constraining decisions: Parent Language Consultant
LD Coordinator LD Teacher
Teacher Psychologist
Principal

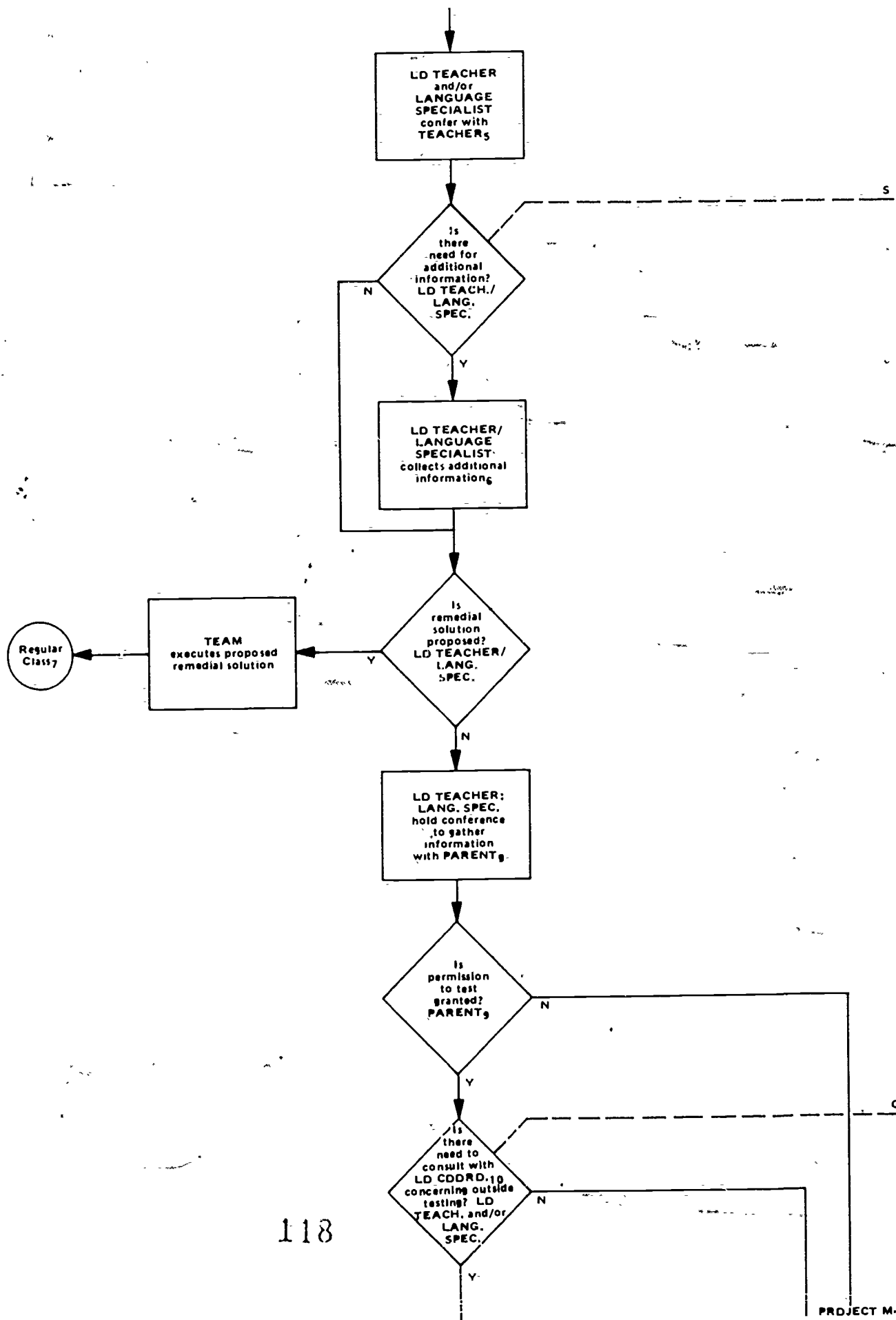
II. SPECIAL NOTATIONS

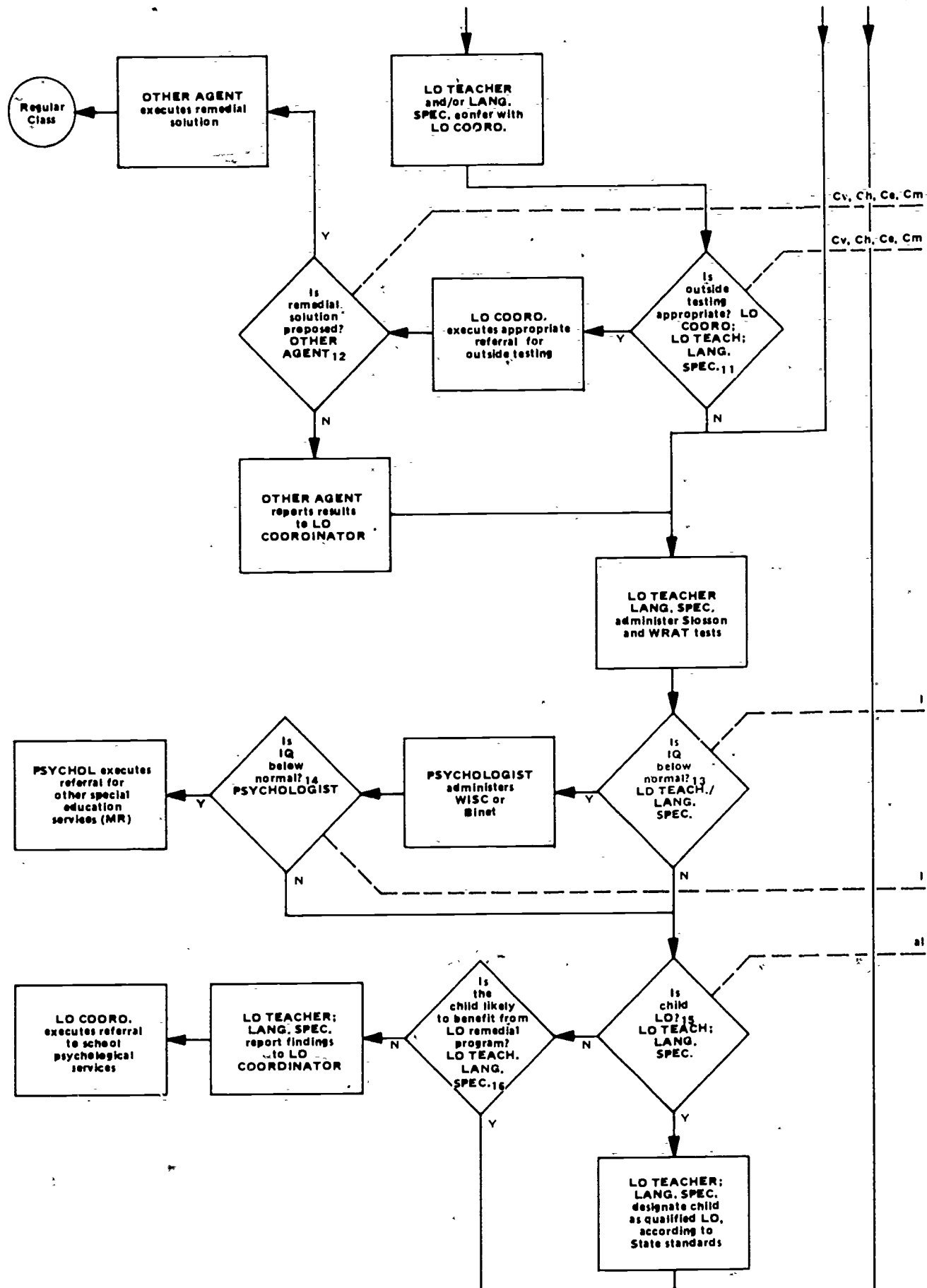
(footnotes apply to notations on flow-chart)

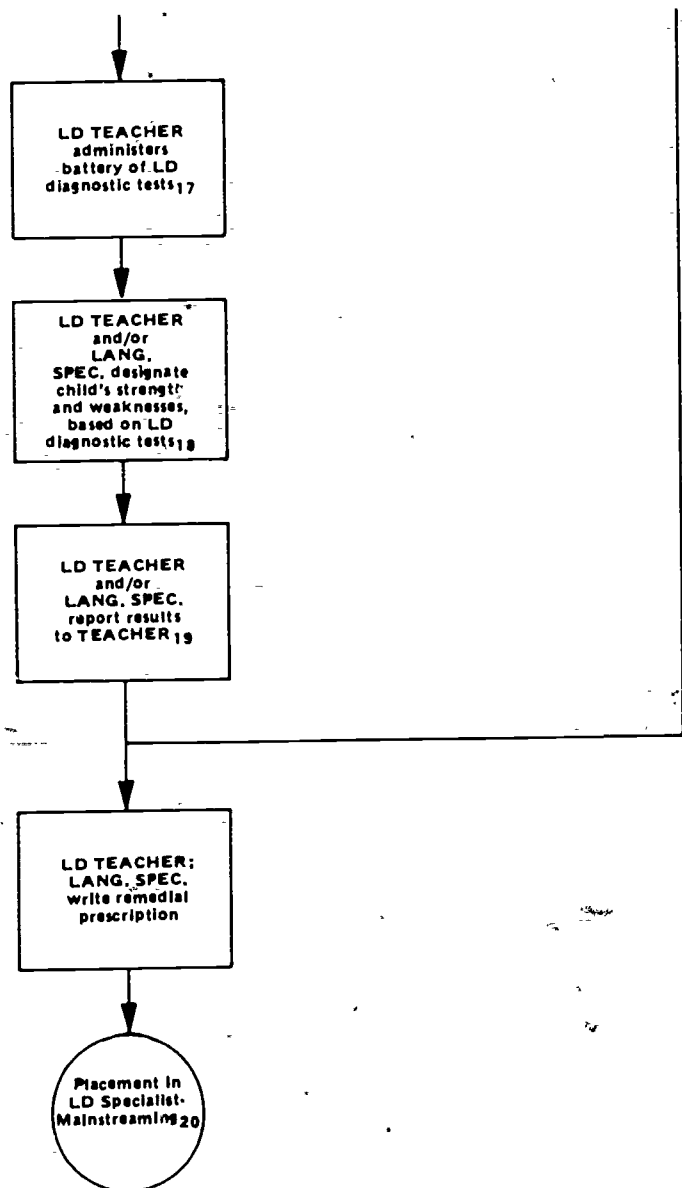
1. Referral form essentially asks the teacher an open-ended question about what is the problem with the child.
2. LD Coordinator is Title VI-G Project Director.
3. Information consists of Teacher Referral, cumulative records.
4. Battery of tests includes achievement tests: (Key-Math; WRAT; Gates McKillop); Locally developed language test; WISC; Bender; Benton; Attitude Scales (e.g., Coopersmith's Self-Esteem Inventory, and others).

Project L-4









I. GENERAL INFORMATION

1. Project Code Letter: M
2. Delivery System for Intervention: LD Specialist Mainstreaming (Grades 1-3)
3. Initial Entry: Referral (Teacher/Parent/Principal/Physician)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent LD Coordinator
Physician Psychologist
Principal Teacher
LD Teacher Language Specialist
Other Agents
 - b) Constraining decisions: LD Teacher
Language Specialist
Parent

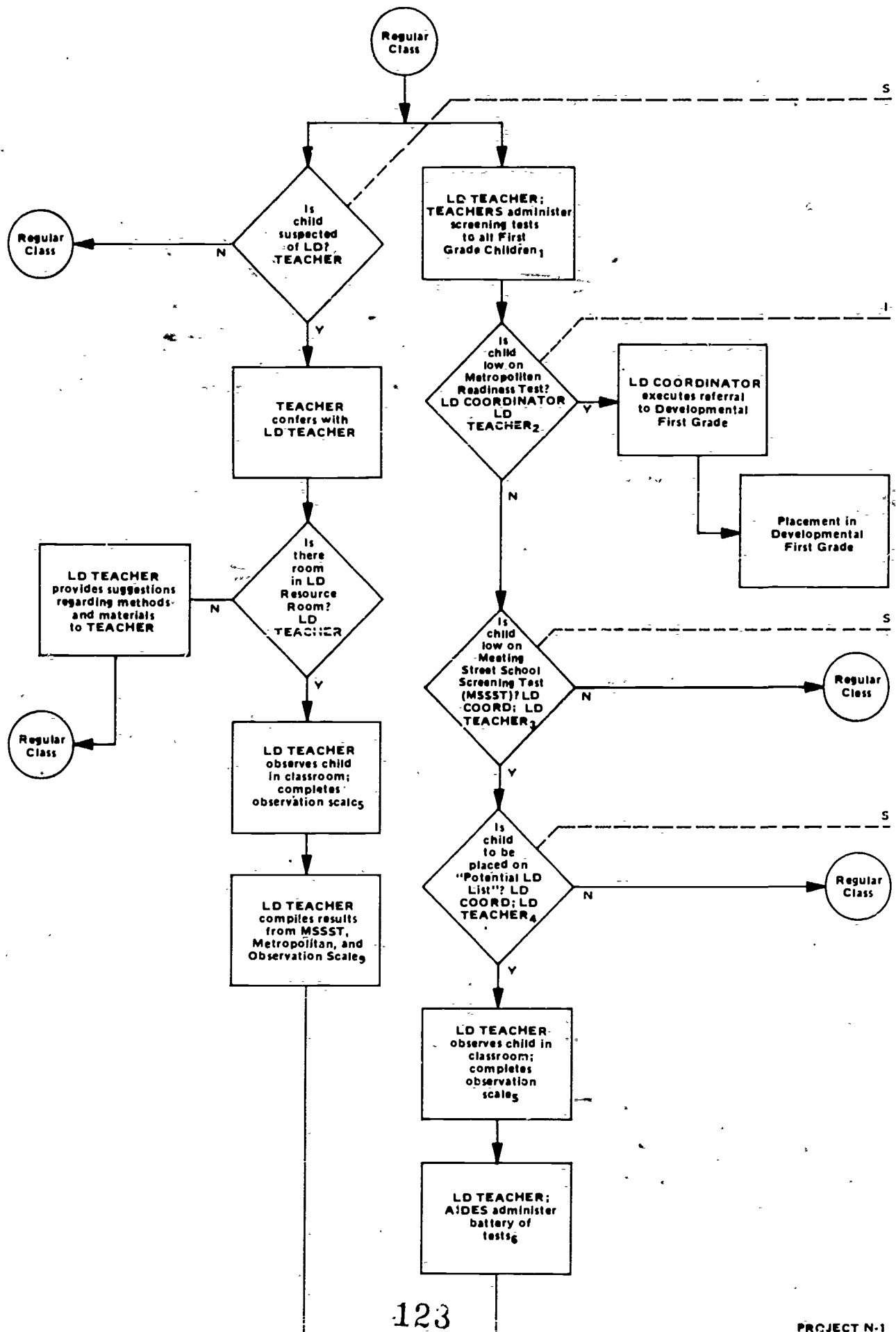
II. SPECIAL NOTATIONS

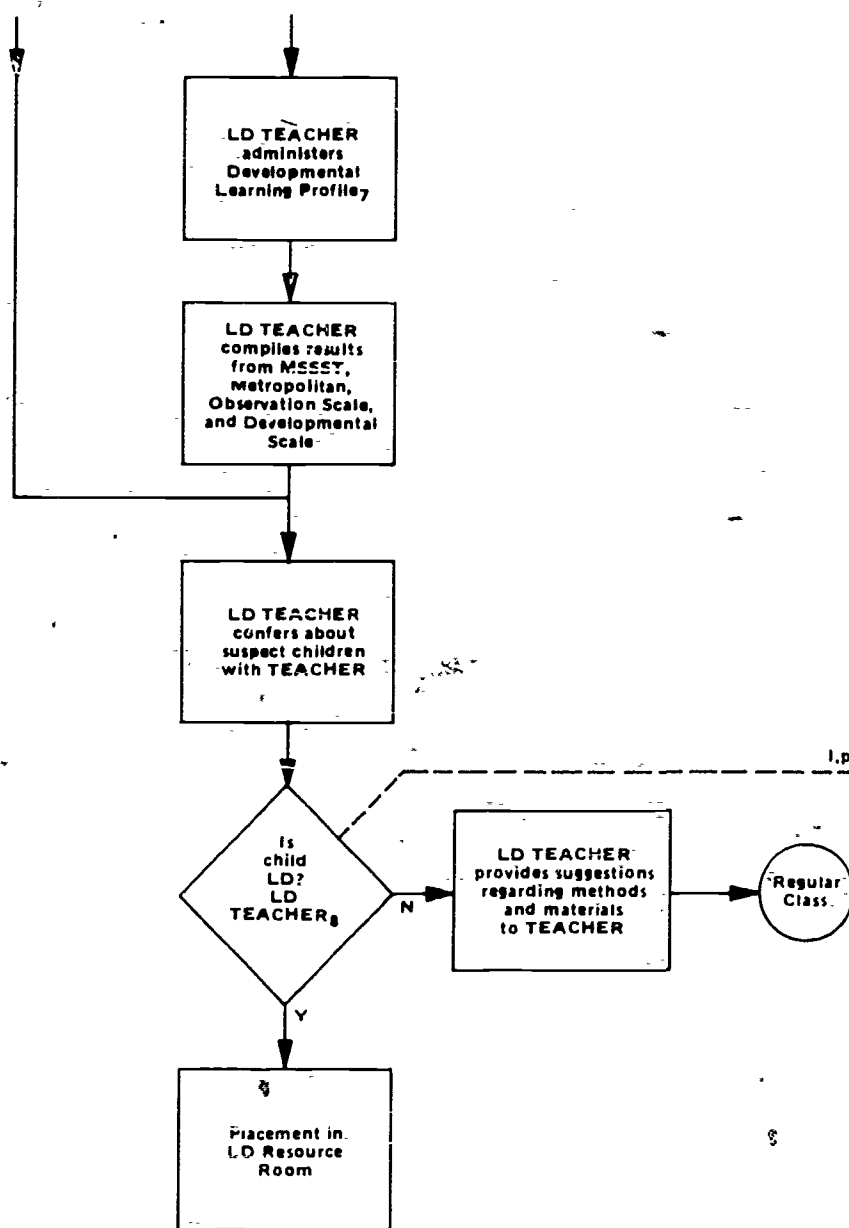
(footnotes apply to notations on flow-chart)

1. Teacher here refers to any member of the teaching team; the children are served in a team-teaching situation; the team consists of two or three regular teachers (Teacher), and Aide, an LD Teacher and a Language Specialist ($\frac{1}{2}$ time).
As a group we will refer to them as the Team (the Team serves in Teaching, Screening and Diagnostic functions).
2. Many events from this point indicate LD Teacher or Language Specialist (LD Teacher/Language Specialist). These two tend to operate in the same roles; which person does a particular thing will depend at a given moment on who is available; no attempt will be made throughout this flow-chart to indicate how a decision is made about which of these two persons performs a given activity or decision.
3. PBRS is the Myklebust scale.
4. In instances where the Teacher has acted as referral agent it may be decided that some other member(s) of the Team will, also, complete a PBRS and other Team member(s) may also be asked.
5. Whichever Team member received the referral from Teacher must attend this conference; purpose of conference is to: a) review the Teacher's PBRS ratings (partially to assist teachers in learning to observe children) and to discuss Teacher's general impressions and ability to cope with the problem now.
6. Additional information includes: a) classroom observation (noting behavior

and what might affect it and doing frequency counts; b) collecting samples of child's work; c) reviewing cumulative records. This is all referred to as baseline data.

7. The child can be brought back through the screening and identification system at any time simply by having one of the Team raise questions about the efficacy at the proposed remedial solution.
8. Purpose is to gather family and medical information.
9. Permission to test is indirect; the parents are informed that testing will be done; testing proceeds without formal permission (i.e., signatures) unless parents object.
If parents object to testing, the child completely by-passes the screening and identification system; the LD Teacher, Language Specialist will write a prescription based on information gathered to that point and begin intervention. This is made possible, of course, by that fact that the children remain in the regular class (team-teaching) to receive LD remediation.
10. LD Coordinator is Title VI-G local Project Director.
11. Outside testing is primarily to check for visual, hearing, motor, psychiatric problems that may be remediated outside of special education.
12. Remedial solutions depend on outside agent, e.g. get glasses, try medication get hearing aid, etc.
13. Borderline IQ on SIT is considered 75-80.
14. Below normal IQ is less than 75.
15. Criterion is that there is a discrepancy between IQ and WRAT; there is no set formula for determining discrepancy; if no discrepancy child still receives services, based on his reasons for referral.
16. Thus, many children who are not classified as LD still continue in the system and receive LD diagnostic tests and LD intervention remedial services; approximately 4% of children in total enrollment classify as LD; another 6% receive service as "possible LD"; the philosophy of the program is to help children whenever possible.
17. LD Teacher chooses from among the following:
PIAT, Frostig, Berry, VMI, ITPA, Silvaroli, Durrell, Wepman, Boehm, BESI, and a selected "Standard Reading Test".
18. This is really a decision-making process; however, it is a whole series of decisions aimed at indicating programming needs and solutions and designating target behaviors for intervention. The decision has already been made concerning his eligibility for LD remediation.
19. Purpose is to get information from Teacher about how they can help on each targeted behavior.
20. Child remains in Team-Teaching regular class, and LD Teacher, Language Specialist execute remedial prescription in that setting.





I. GENERAL INFORMATION

1. Project Code Letter: N
2. Delivery System for Intervention: LD Resource Room (Grade 1)
3. Initial Entry: Mass Screening (Meeting Street School Screening Test)
Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
LD Coordinator
LD Teacher
 - b) Constraining decisions: LD Teacher

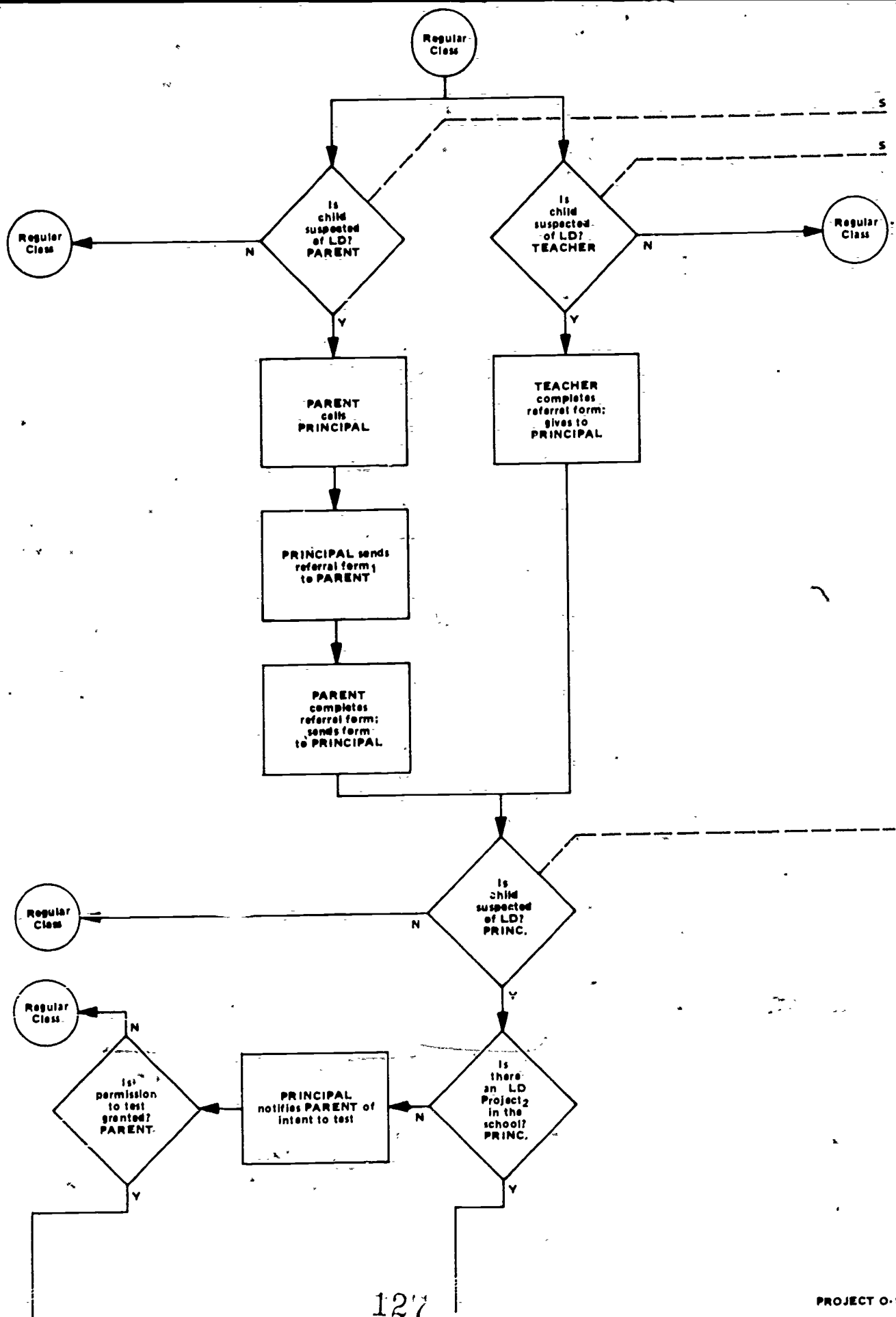
II. SPECIAL NOTATIONS

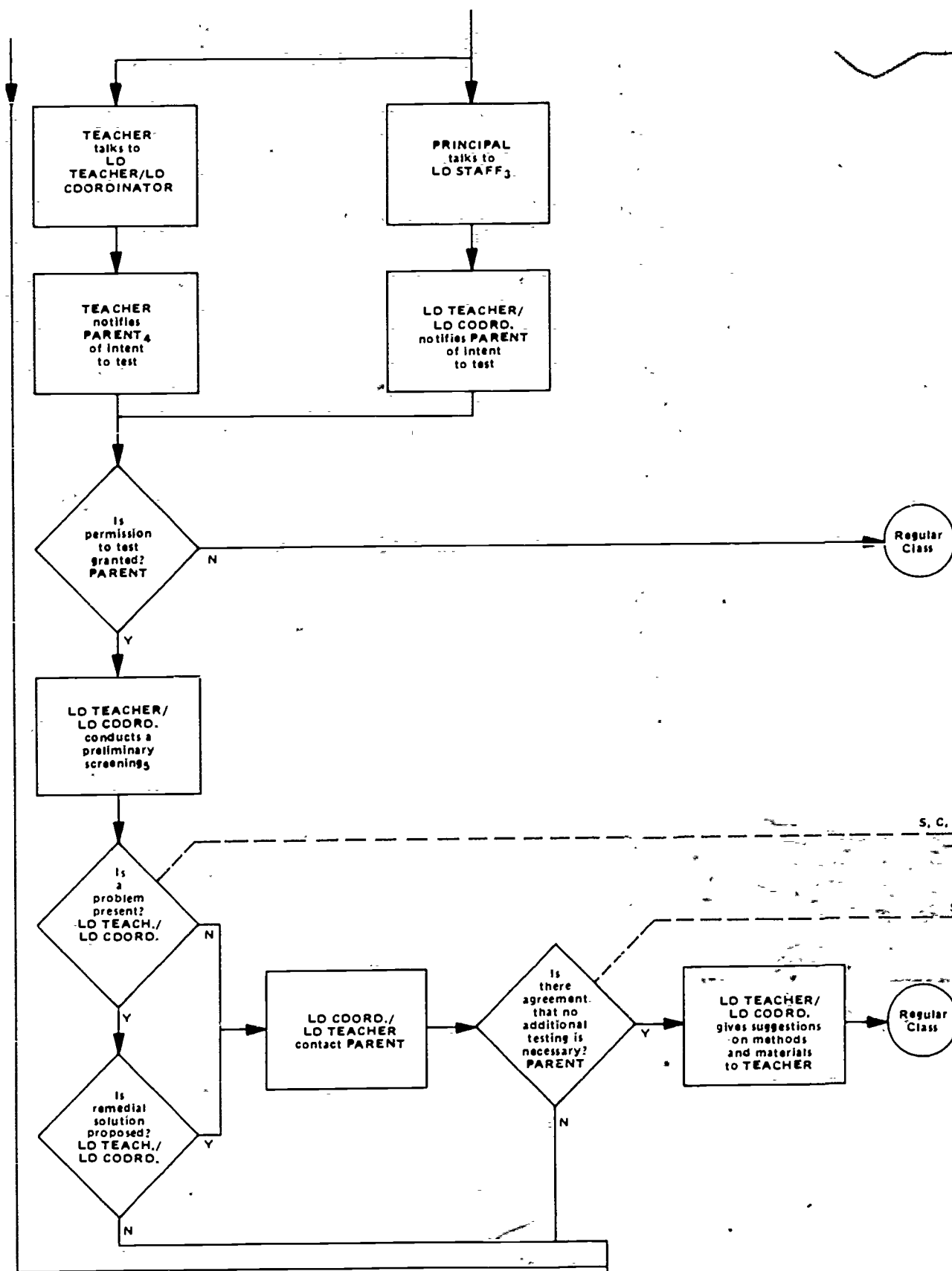
(footnotes apply to notations on flow-chart)

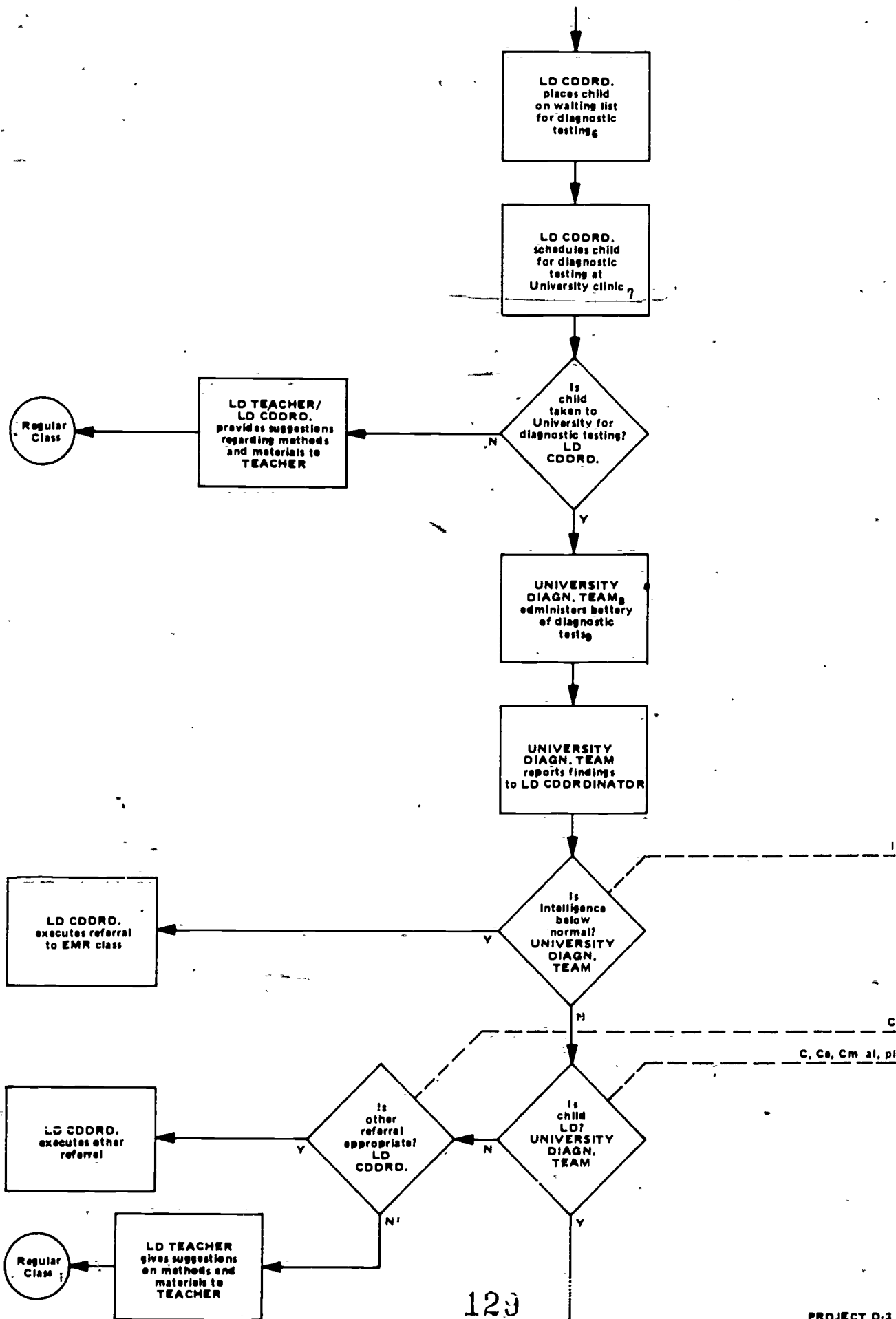
1. Screening tests were given to all first grade children (N=217) prior to or at school entrance (80-90% were tested in the summer; the remainder at time of school entrance); all target school first grade teachers assisted. The screening tests were: a) The Meeting Street School Screening Test (MSSST), and b) The Metropolitan Readiness Test.
2. LD Coordinator is Title VI-G Project local director; LD Teacher is responsible for coordinating all remediation done by her and three aides. The LD Teacher takes a heavy role in the decision-making throughout the process. No specific criteria are available concerning the cut-off for the Metropolitan.
3. The exact criteria for being "low" on the MSSST are not know; however, the LD Coordinator, LD Teacher state that the regular cut-off on the MSSST created "too many children".
4. The LD Coordinator and LD Teacher apparently took the 30 or 35 "most suspect" children to continue in the system. Although 217 children were tested in three schools, children were only eligible to receive LD Resource Room intervention if they were in one particular school, which had 90 first graders. Thus, about one-third, or more of the targeted pool of children were considered "suspect" at this point. A limit of 25 children was imposed on the enrollment in the LD Resource Room. Thus, the process from this point on is essentially aimed at narrowing the "suspect list" to 25. Children who were tested in the other two schools did not receive intervention service by the LD Teacher; however, suggestions for classroom intervention were given.
5. The "Observation Scale" was designed by the LD Teacher. It was a combination of several available scales.
6. Battery of tests was intended to be used as "baseline data" by evaluator.

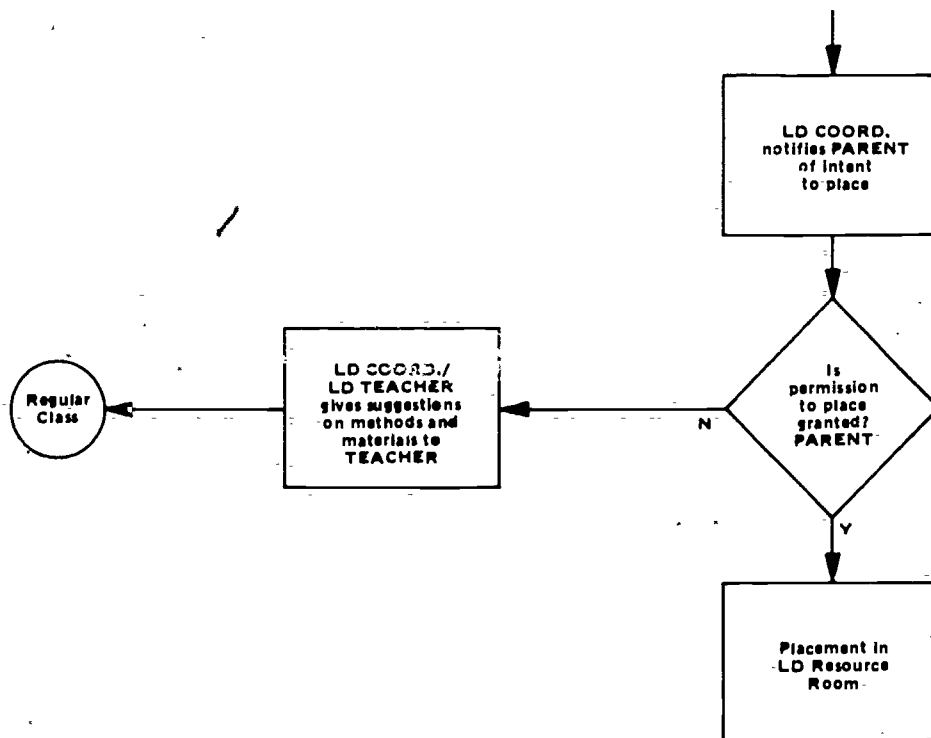
However, these data were never used in the decision-making by the LD staff. Tests were measures of: a) arithmetic concepts, b) Piagetian concepts, and c) motor abilities.

7. This is the "Behavioral Developmental Profile", developed in Marshalltown, Iowa. It is a composite of developmental items rated as "completed" or "uncompleted".
8. Criteria for LD were primarily derived from MSSST and Developmental Scale: Decisions were made by the LD Teacher. She looked for a) low verbal; b) low visual; c) low auditory on the MSSST, paying little attention to the motor items (the precise criteria for these "lows" are unknown; they essentially represent the judgment of the LD Teacher based on available information). The Developmental Profile was used to eliminate children "not developmentally at their level". Apparently, the children eliminated at this point were "low ability children", not LD; they simply remained in the regular classroom, with some suggestions given to the teacher.
9. This is precisely the process followed with those originally picked up by MSSST screening, except that the Developmental Learning Profile (see note 7) is not given. The LD Teacher states that "it's not going to tell anything that the MSSST won't tell." Also, by this time the teachers know the children well enough that they do not tend to refer "low" children or children with "other problems."









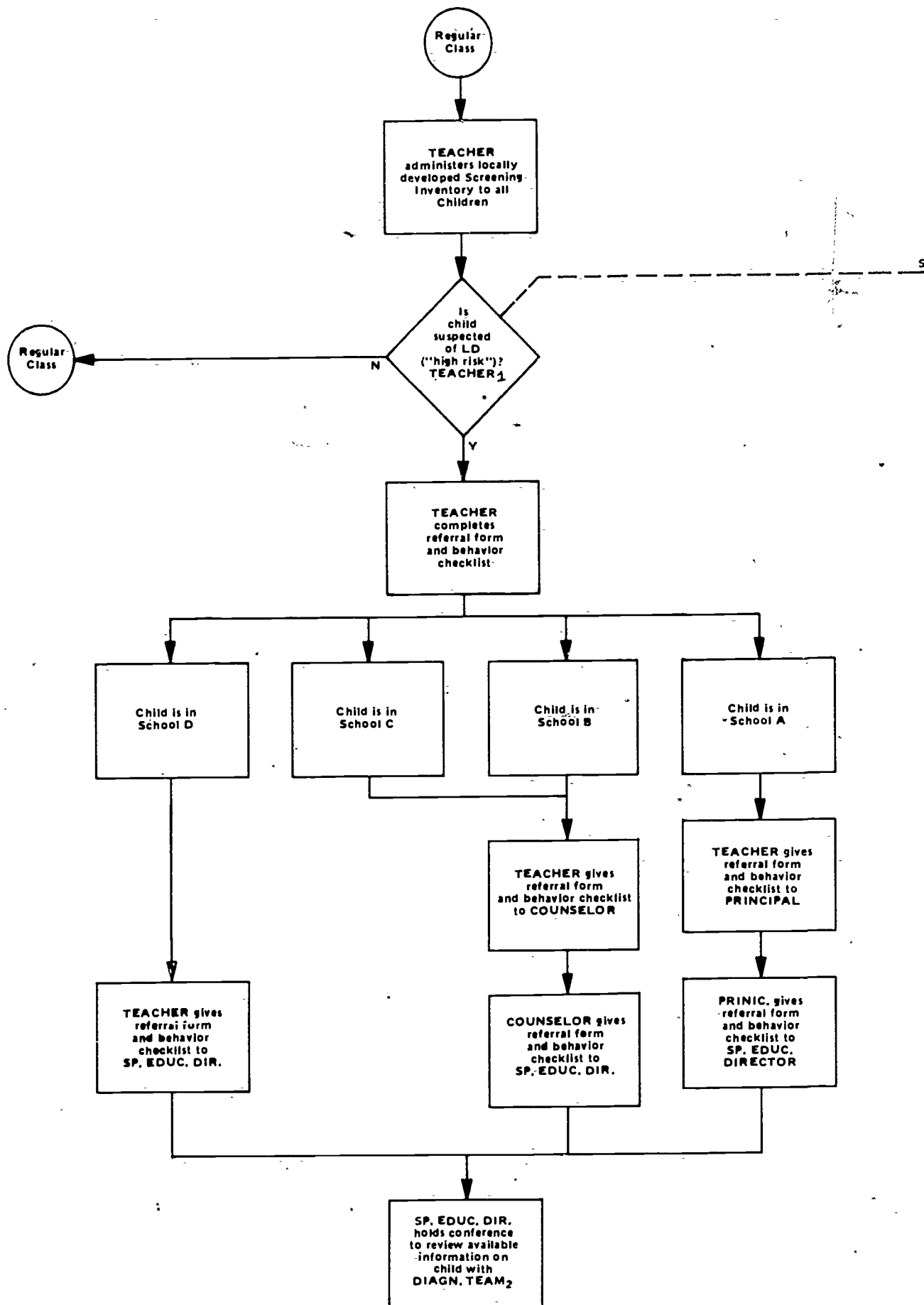
I. GENERAL INFORMATION

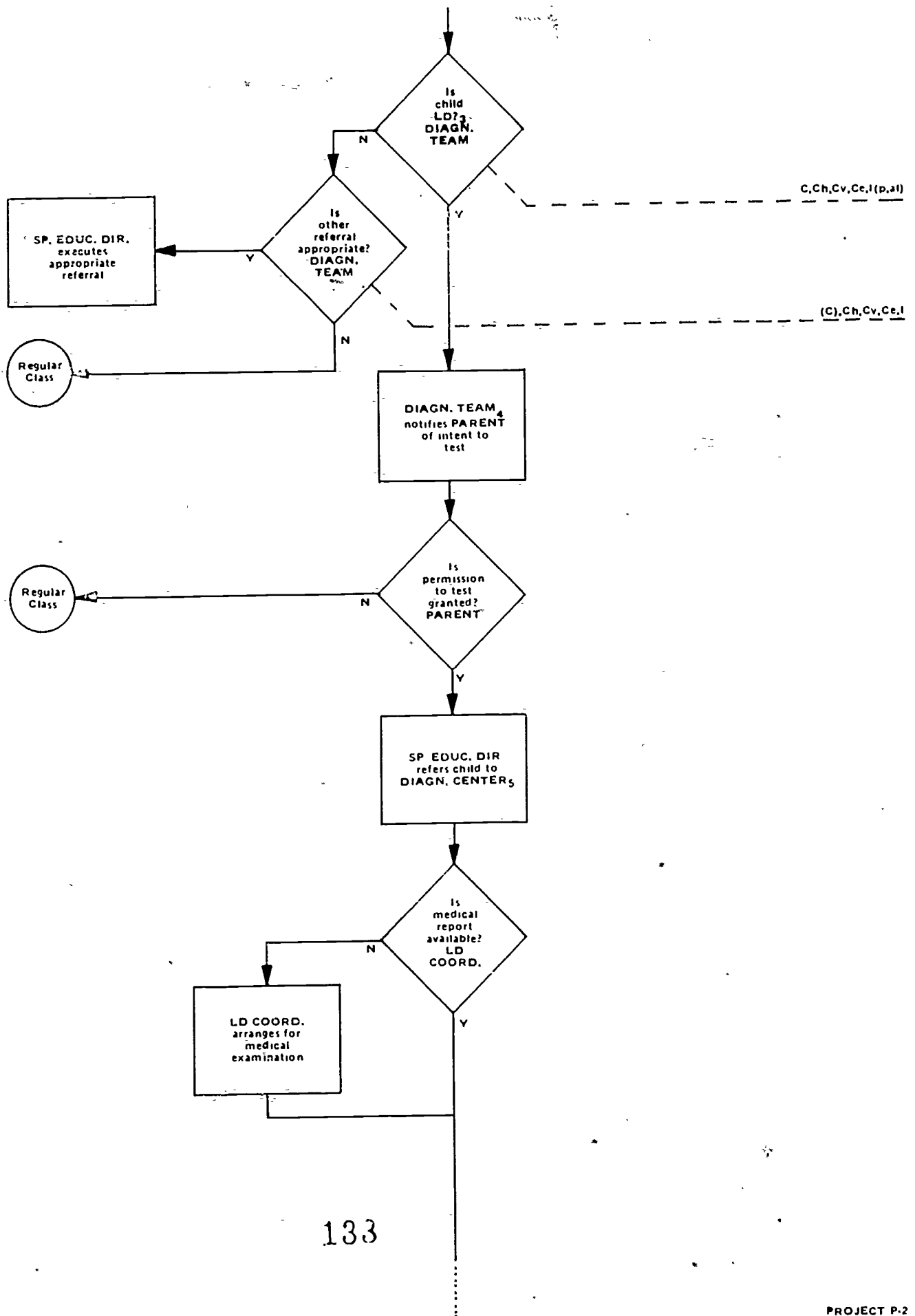
1. Project Code Letter: O
2. Delivery System for Intervention: LD Resource Room (Grades 1-3)
3. Initial Entry: Referral (Teacher/Parent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher University Diagnostic Team
Parent (Social Worker, Psychologist,
Principal Speech & Hearing Clinicians,
LD Teacher Educational Consultant)
LD Coordinator
 - b) Constraining decisions: Principal
Parent
LD Teacher
LD Coordinator

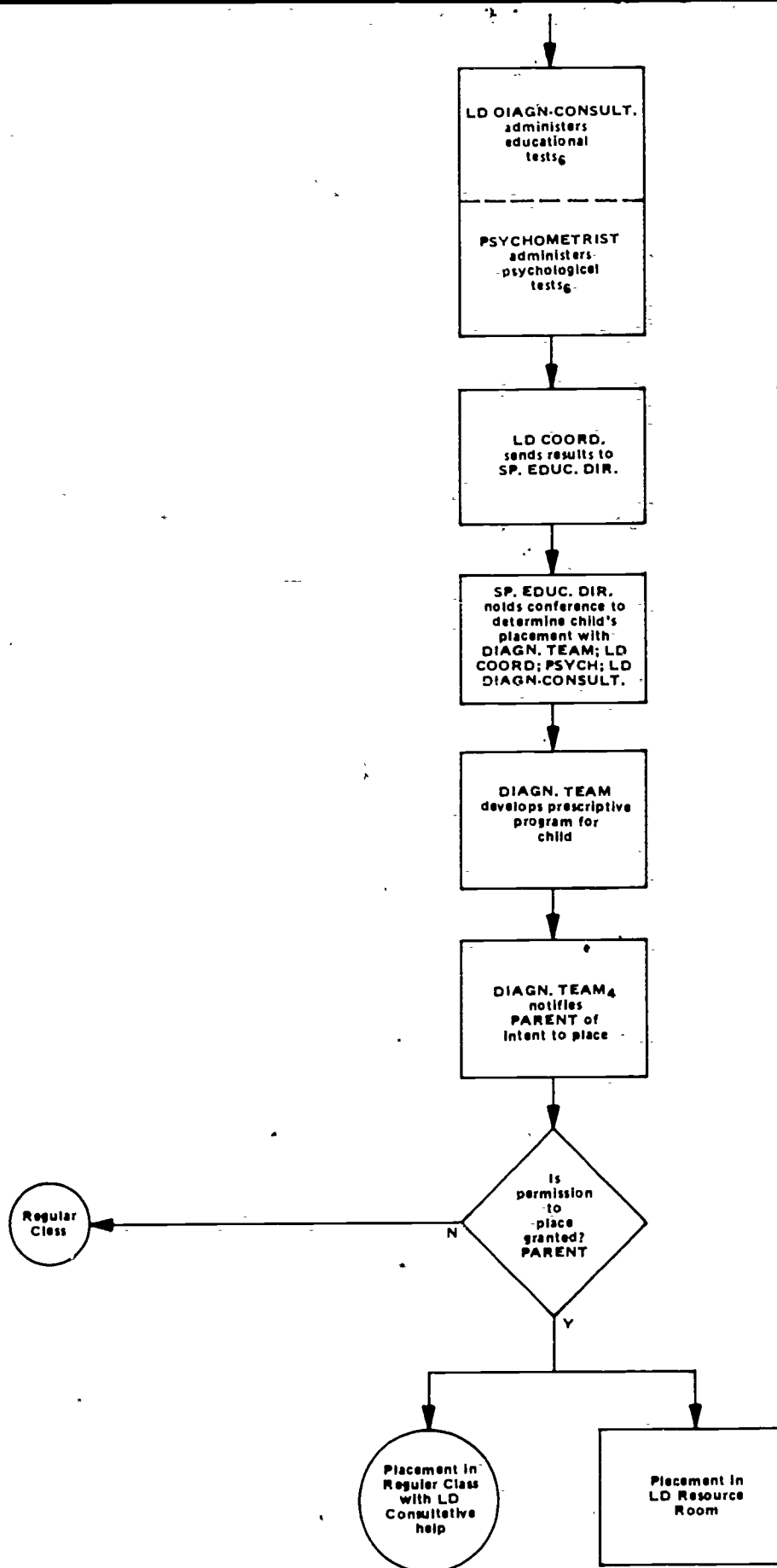
II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

1. Referral form is primarily identifying information and statement of the problem, plus some case history.
2. LD Project means Title VI-G Project, which serves only certain schools, and is headed by the LD Coordinator.
3. LD Staff includes LD Coordinator, LD Teachers; whenever the term LD Staff appears, it means that any one of the staff may perform that function.
4. In instance where Teacher contacts LD Staff, it is because Principal requested or was unavailable.
5. Screening consists of filling out Learning Disabilities Check List, a combination of locally developed form and the Rocky Mountain Checklist (Classroom Screening Instrument).
6. The waiting list is prioritized by the LD Coordinator.
7. University Diagnostic Team is located about 20 miles from the School District. However, they come as a group on some days to the District and children are scheduled for testing at the School Board offices.
8. The University Diagnostic Team consists of a Social Worker, a Psychologist, a Speech & Hearing Clinician (2), and an LD Diagnostician.
9. Testing includes WISC, Draw-A-Person, Gilmore, Stanford Achievement Tests, ITPA, Bender.







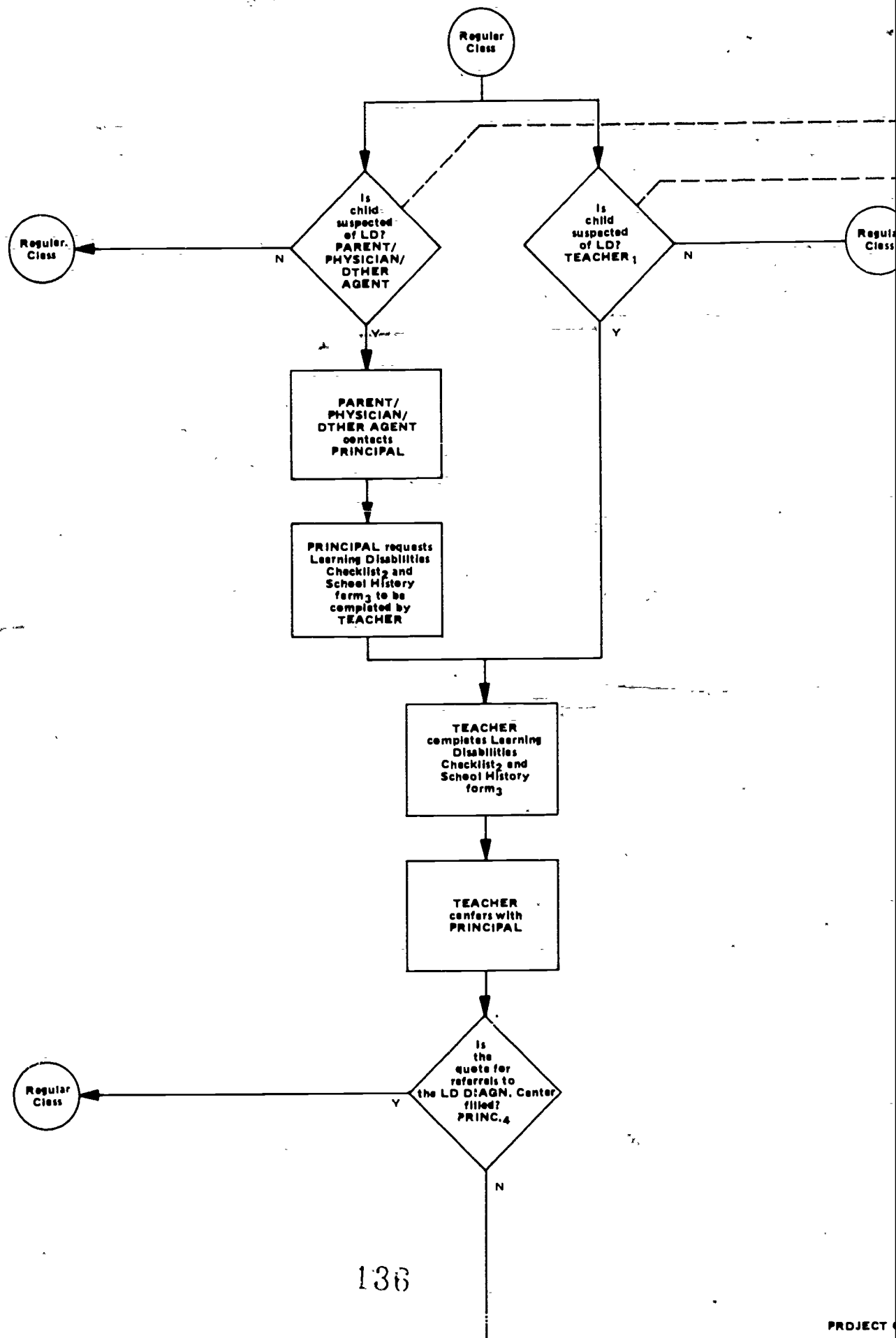
I. GENERAL INFORMATION

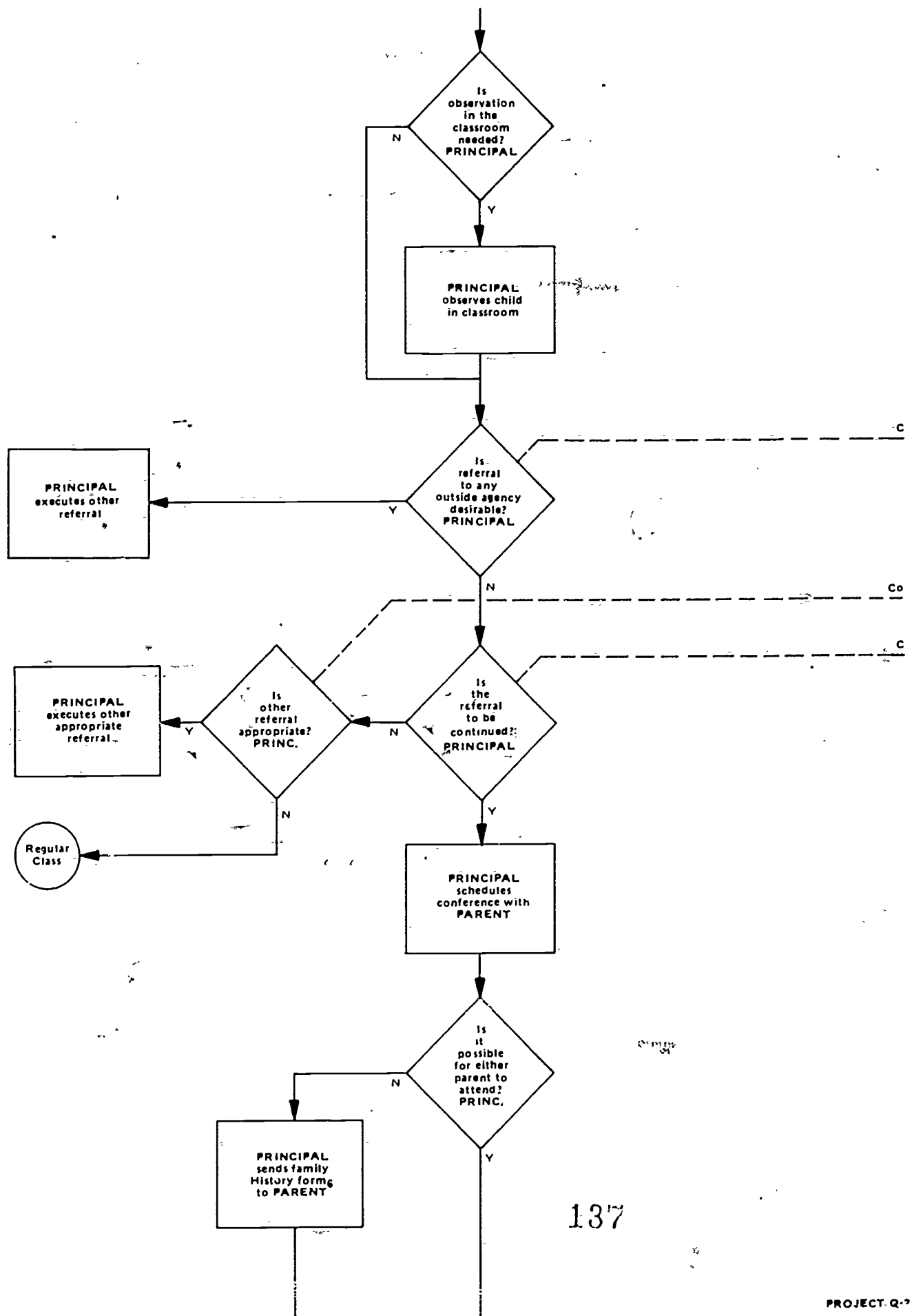
1. Project Code Letter: P
2. Delivery System for Intervention: LD Resource Room (Grades 7-8)
LD Consultative
3. Initial Entry: Mass Screening (locally developed)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Diagnostic Team (Director of Special Education,
Psychologist, Teacher, Counselor,
Principal, Nurse, Social Worker,
LD Diagnostician-consultant)
 - b) Constraining decisions: Parent
LD Coordinator

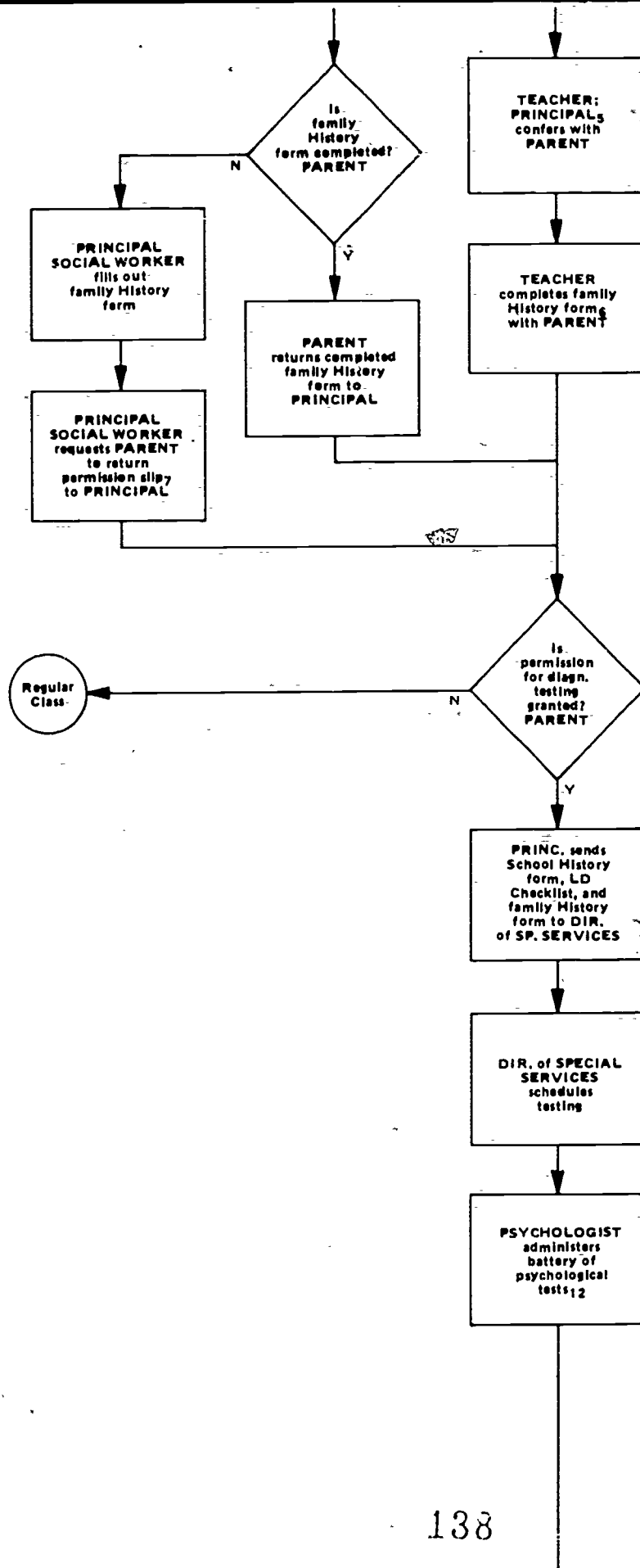
II. SPECIAL NOTATIONS

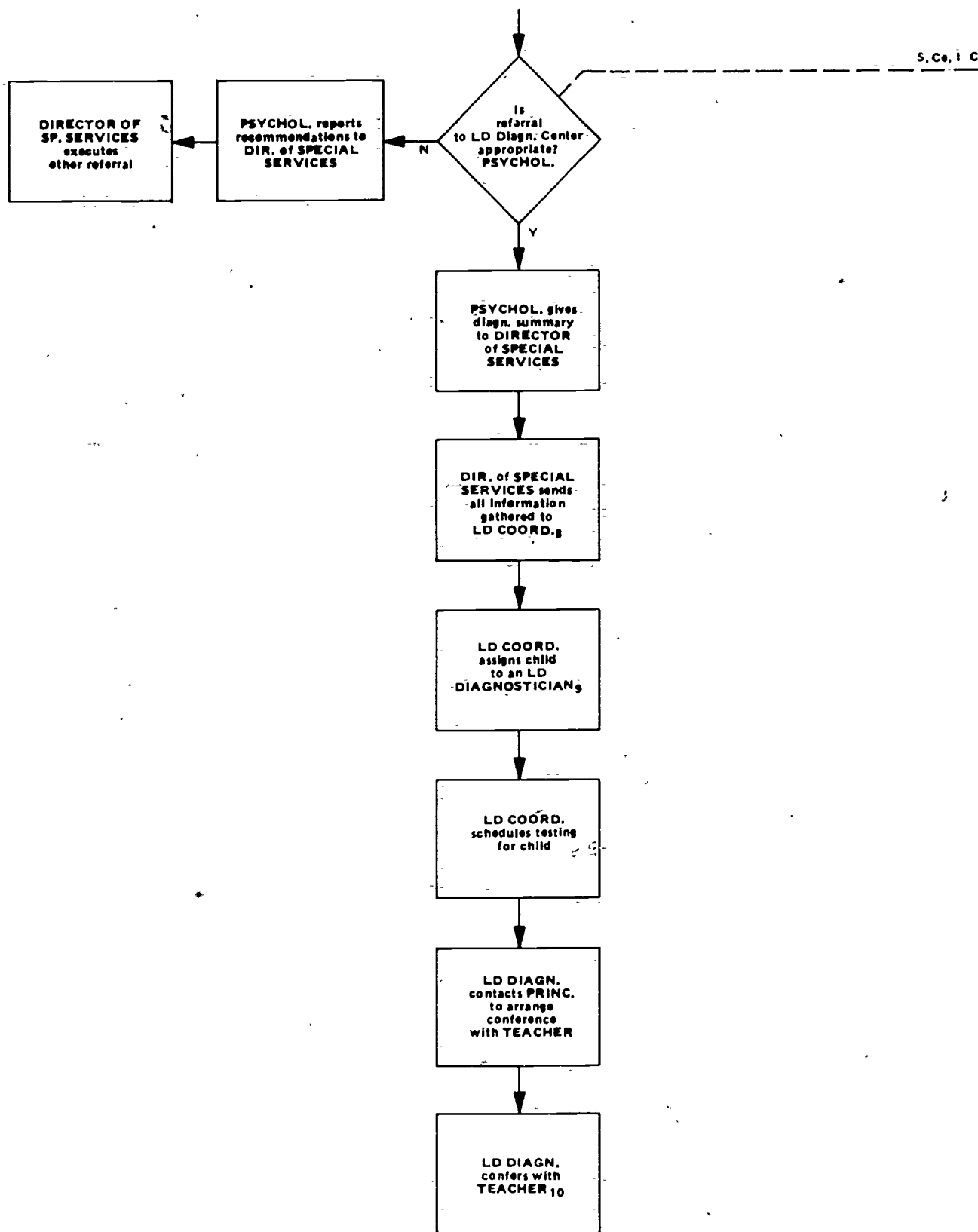
(footnotes apply to notations within flow-chart)

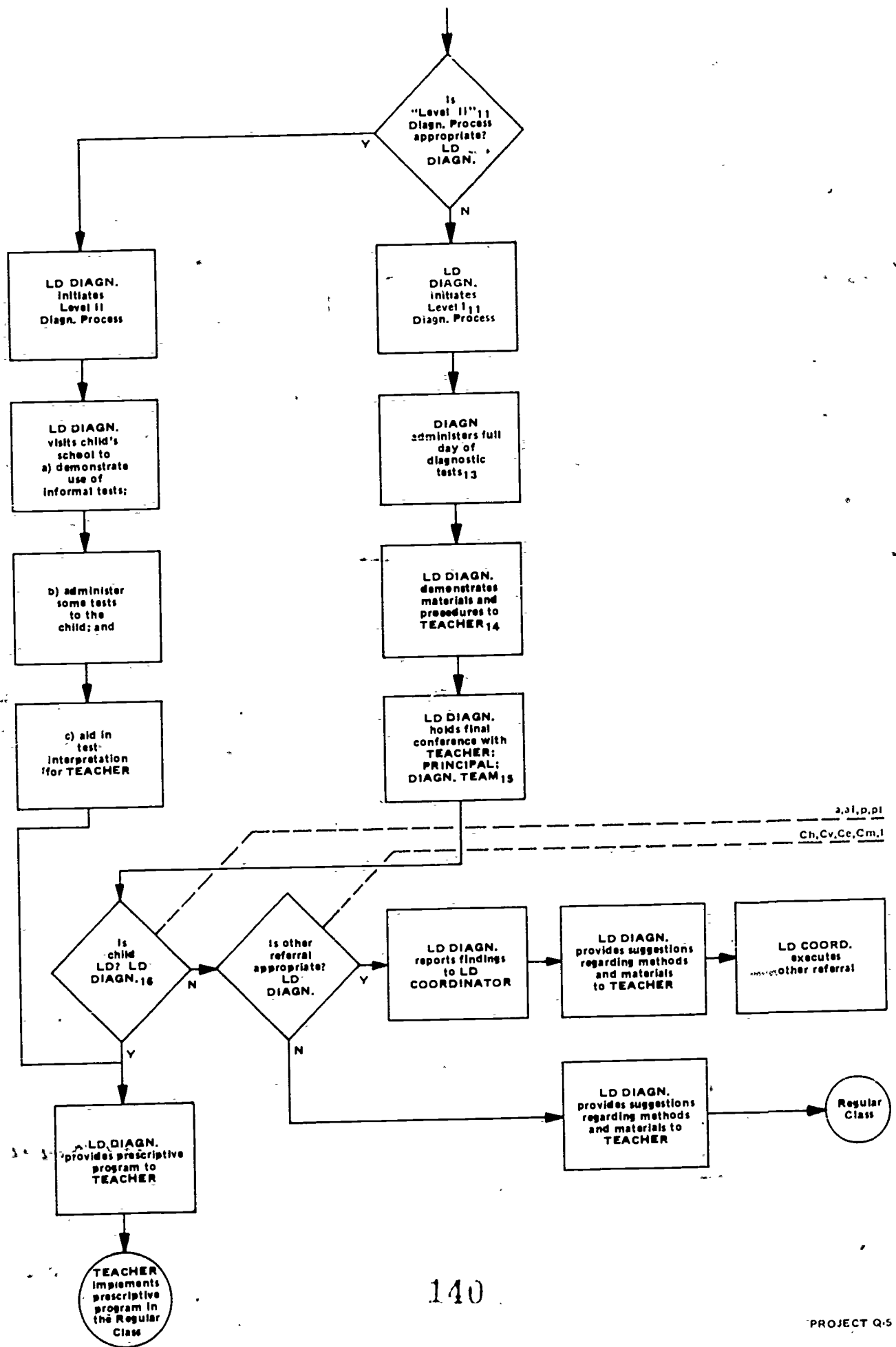
1. Cut off scores will be established after the instrument is piloted.
2. Includes Director of Special Education, Psychologist, Teacher, Counselor, Principal, Nurse, Social Worker, LD Diagnostician-Consultant. Available information from referral and checklist include school history, medical history, test scores from cumulative file (IQ, vision, hearing, Bender-Gestalt, Slingerland or Malcomesius, or MSSST.
3. Specific criteria are not clearly defined. It is assumed that MR and ED (BD) are screened out, since these are not to be reviewed at Diagnostic Center (next step). It is also assumed that sensory handicaps are eliminated since rather detailed vision and hearing report is included on referral form.
4. No particular person specified, although probably this is done by the social worker.
5. The Center is an outside agency serving the school district, and responsible for the diagnostic evaluation of the child.
6. Psychological battery includes WISC, Bender-Gestalt, some self-esteem inventory. Educational battery includes Goldman-Fritol-Woodcock Test, Detroit Test, Durrell analysis of reading, informal penmanship test, copying exercise, key math, interest inventory, gross motor measurement, memory for designs test, writing alphabet from memory, Durrell word recognition, Stanford reading, Gilmore oral reading test, Fry's phonics criterion test, Ayer's spelling test. All children would not receive complete battery.

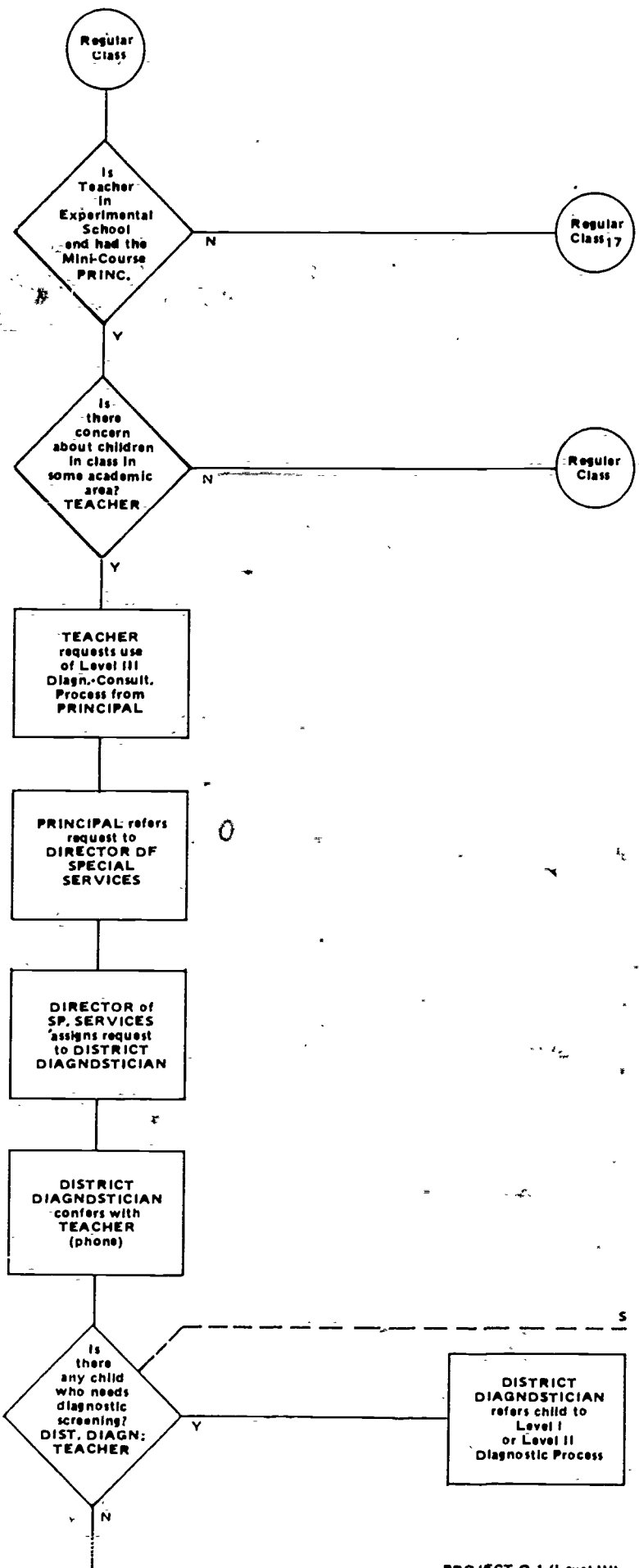


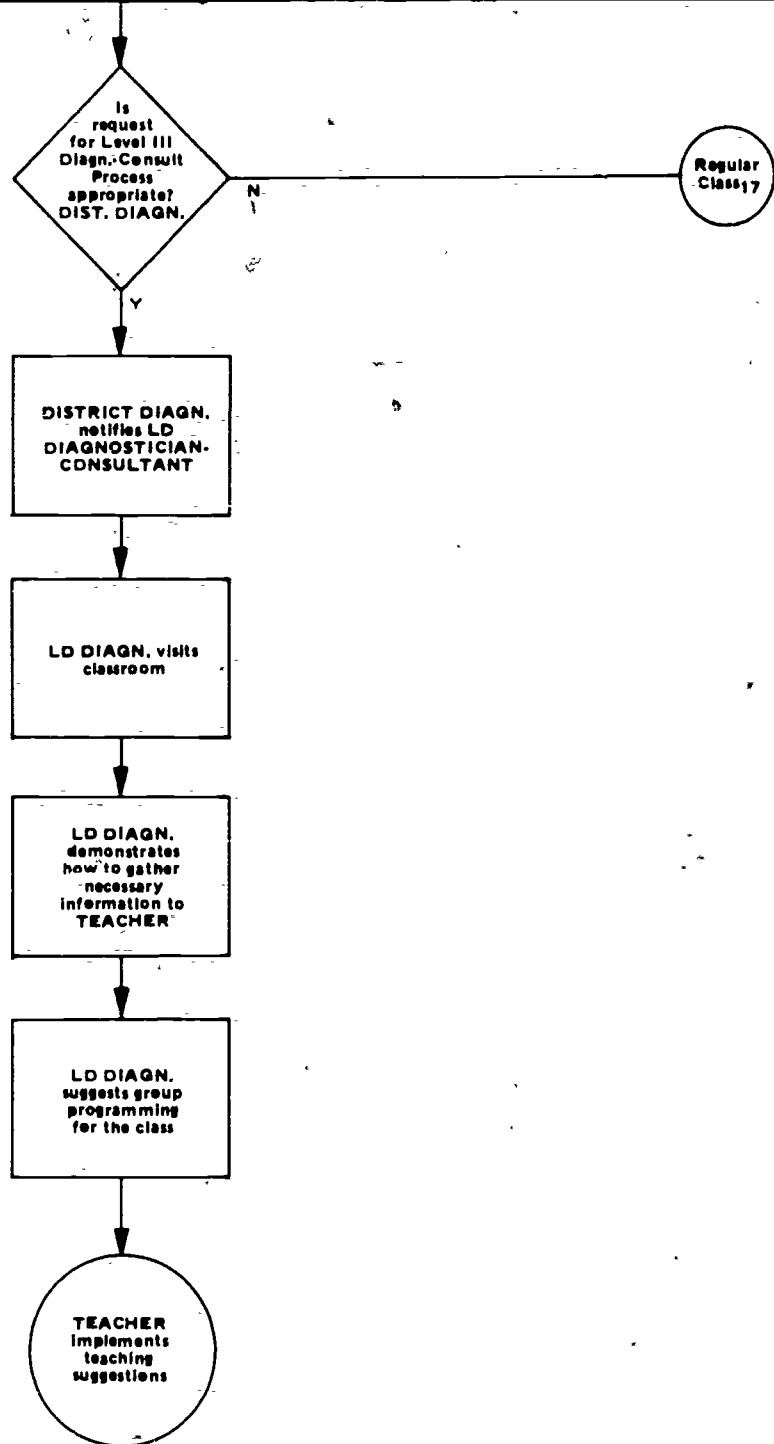












I. GENERAL INFORMATION

1. Project Code Letter: Q
2. Delivery System for Intervention: LD Consultative (Grades K-12)
3. Initial Entry: Referral (Teacher/Parent/Physician/Other Agents)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher LD Coordinator
Parent Principal
Physician Psychologist
Other Agents LD Diagnostician
Diagnostic Team (Social Worker,
Speech Correctionist, School
Diagnostician, Reading
Teacher)
 - b) Constraining decisions: Teacher
Parent
Principal
LD Diagnostician
District Diagnostician

II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

1. Before referring a child the Teacher must have attended a "Mini-course" for in-service training regarding LD, the Diagnostic Center processes, and referral procedures.
2. Checklist is a locally developed form.
3. School History form is comprehensive, including general information, results from previous testing, family history, medical information, educational history and home observations. Teacher fills out appropriate portions at this stage.
4. Because the LD Diagnostic Center is a special project, an attempt is made to serve several schools and to distribute the services.
5. Principal's presence is optional.
6. Family History form is the portion of the School History form not already completed by the Teacher.
7. Permission slip if final sheet of School Family form.
8. LD Coordinator is Title VI-G local Project Director, and Director of the LD Diagnostic Center.

9. This is a decision-making event, since the LD Coordinator tries to "match" the child and tester, according to type of suspected problem and competencies of testers. The LD Diagnostician is a Diagnostician-Consultant; however, the term LD Diagnostician will be used throughout this flow-chart.
10. Conference may be by phone or by visitation of the Teacher to the LD Diagnostic Center.
11. Level I is the "regular" process; it is described as follows:

<u>Procedure</u>	<u>Focus</u>
1. Regular referral process.	1. Diagnostic-prescriptive process around one child.
2. Child seen at the Center.	
3. Regular follow-up at ten weeks.	2. In-service training in use of special materials.

Initially, a child is identified by his teacher, tested by the district's diagnostician, and accompanied by his teacher to the Center for testing. At the end of the testing day a prescriptive case staffing is held (participants: teacher, principal, district's diagnostician, reading teachers, speech therapists, social workers) and an educational prescription is designed to ameliorate the child's learning problems. A follow-up is scheduled to evaluate the child's progress approximately ten weeks later.

Level II is available only to Teachers who have had the Mini-Course and have had a child tested at the LD Diagnostic Center. It is as follows:

<u>Procedure</u>	<u>Focus</u>
1. Regular referral process.	1. Diagnostic-prescriptive process with higher level of involvement by teacher.
2. Consultant goes to the school for testing, assisting teacher in carrying out further testing.	2. In-service training in working "on-going" with consultant on programming.
3. Consultation: programming.	

This level is identical to Level I except that after the child has been tested by the district's diagnostician, the Center's diagnostician-consultant visits the school to offer the appropriate services. The Center's diagnostician will demonstrate the use of informal test instruments, test, aid the teacher in the interpretation of test results, and offer ideas around educational programming. Generally speaking, the focus in Level II will be on in-service teacher training as well as diagnostic service.

In certain circumstances Level II will require a substitute for one half a day. This will enable the diagnostician-consultant to work more intensively around the interpretation of diagnostic test results and educational programming.

In addition, there has been instituted a Level III Diagnostic Process, available only to certain experimental schools and to Teachers who have had the Mini-Course. This process is described as follows:

<u>Procedure</u>	<u>Focus</u>
1. Teacher refers several students directly.	1. Classroom management - programming by teacher.
2. Consultant meets to clarify problems, evolve plan.	2. Teacher becomes primary data collector.
3. On-going consultation.	3. Consultant: interpretation, teacher support.

Level III will be offered to experimental schools throughout the project's constituency, (one school per district). Similar to Level II, Level III in certain circumstances will require a substitute for one half a day. This will enable the diagnostician-consultant to work more intensively around the interpretation of diagnostic test results and educational programming. Level III is different in four important ways:

- a. Instead of referring one child a teacher would refer his "entire classroom", that is, all the children in his classroom with whom there are difficulties in learning in some academic areas. The referral process will continue to be funneled through the Special Services Department of each school district.
- b. The children in Level III would not necessarily need a diagnostic screening by the district's diagnostician. However, a conversation between the teacher and the district's diagnostician (or other designated person) will be necessary to reduce the number of inappropriate referrals.
- c. Instead of the diagnostician-consultant doing testing at the Center the teacher will be shown how to gain the necessary kinds of diagnostic information in his own classroom.
- d. Instead of programming for one child at the Center the teacher will receive ideas for programming with several children within the framework of his own class setting.

Level III is so unique that a separate flow chart is provided following the completion of the regular flow-chart, which considers only Levels I and II.

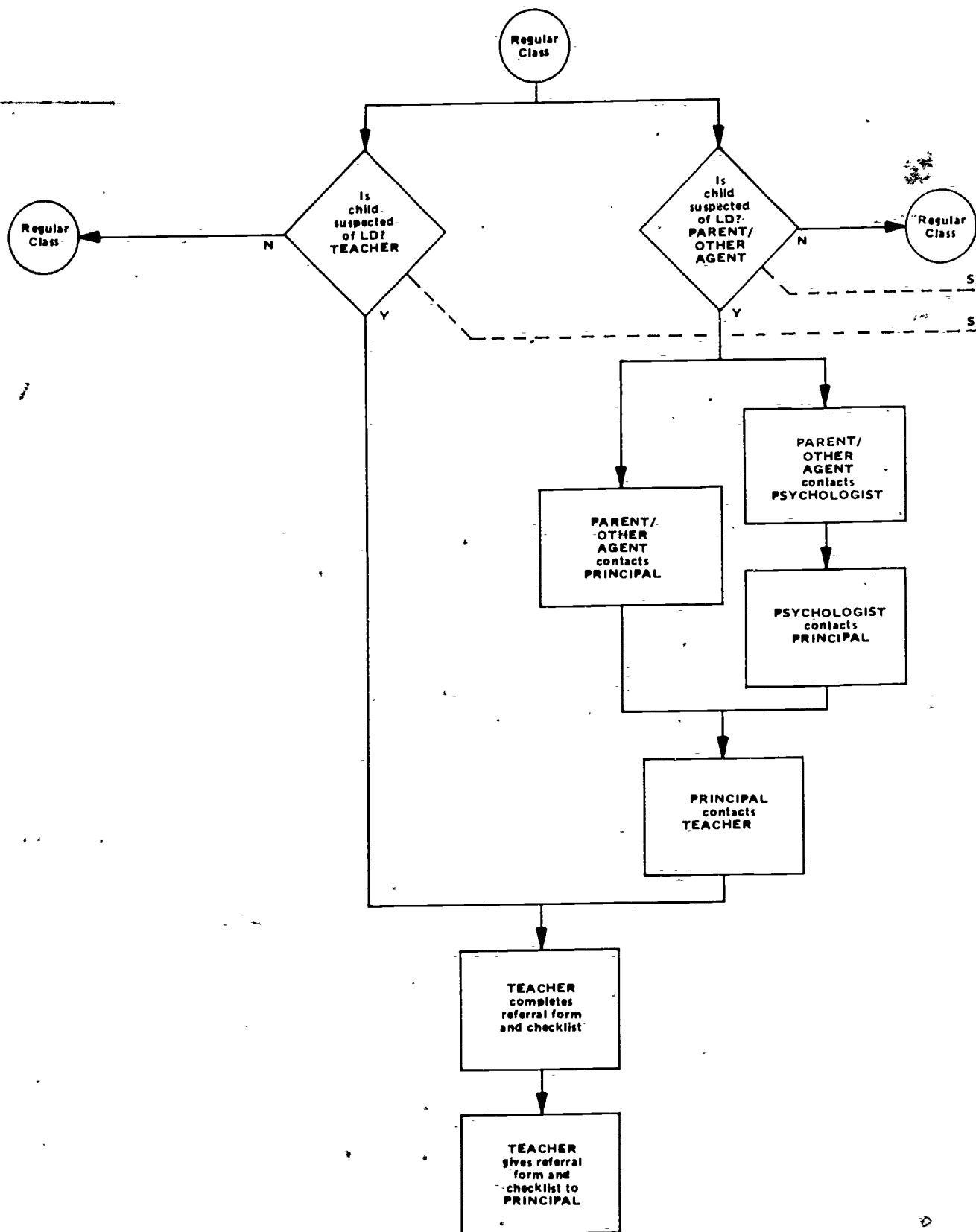
12. Diagnostic tests include Binet or WISC, Goodenough, ITPA, Bender, WRAT.
13. The battery of test varies substantially, and is the choice of the LD Diagnostician exclusively. Tests are generally academic, specific ability and cognitive tests. Goal is to find child's strengths and weaknesses and identify target behaviors for intervention.
14. Demonstration of materials is geared toward those which will be useful with child being tested.
15. Diagnostic Team includes any persons who have pertinent information on

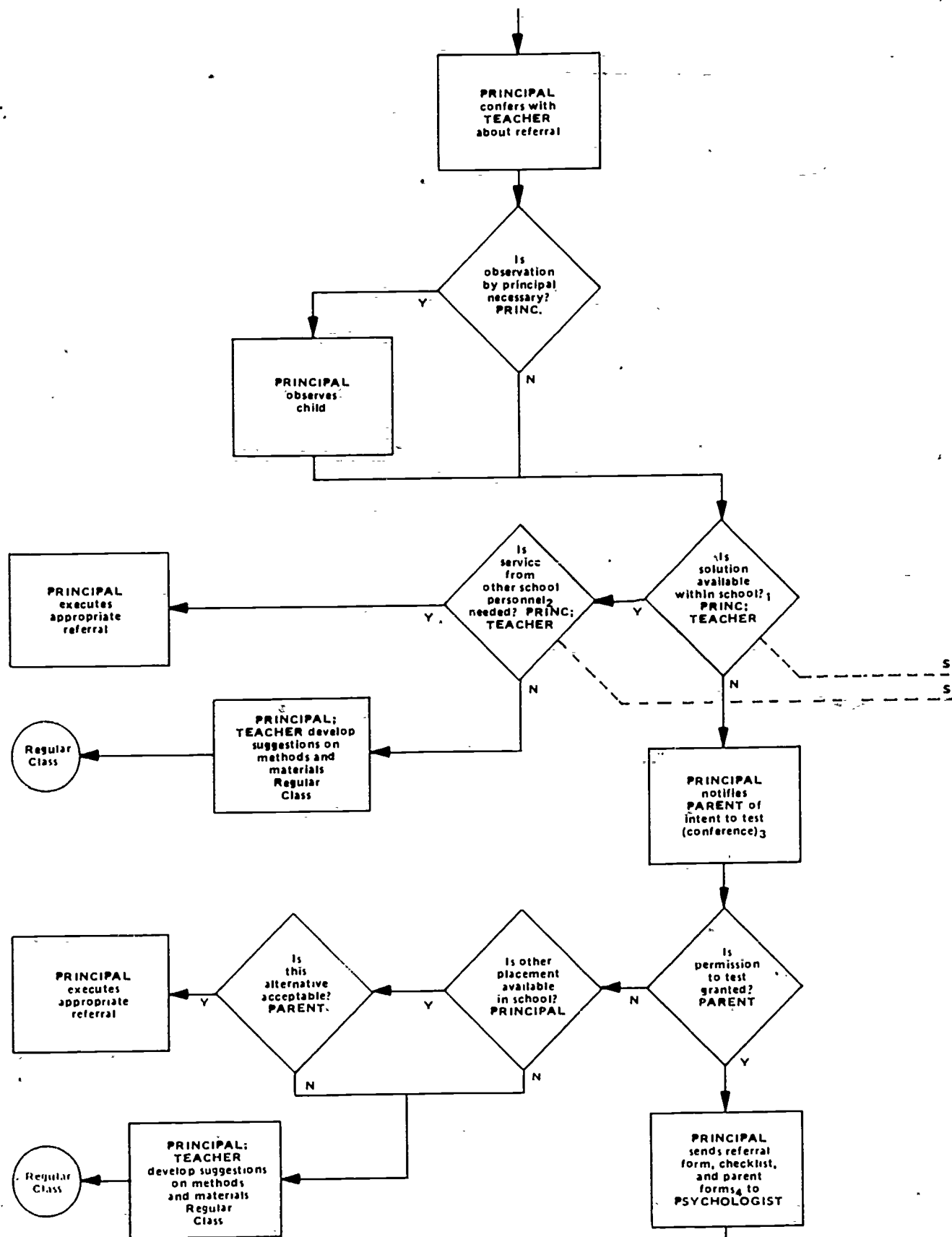
the child, i.e., Teacher, Principal, plus other optional staff: Speech Clinician; Social Worker; School Diagnostician; Reading Teacher, etc. (occasionally a Parent attends).

The LD Diagnostician suggests a) profile and skill levels, and b) prescriptive program (materials; management techniques; time blocking, etc.). Other members of Team modify if necessary.

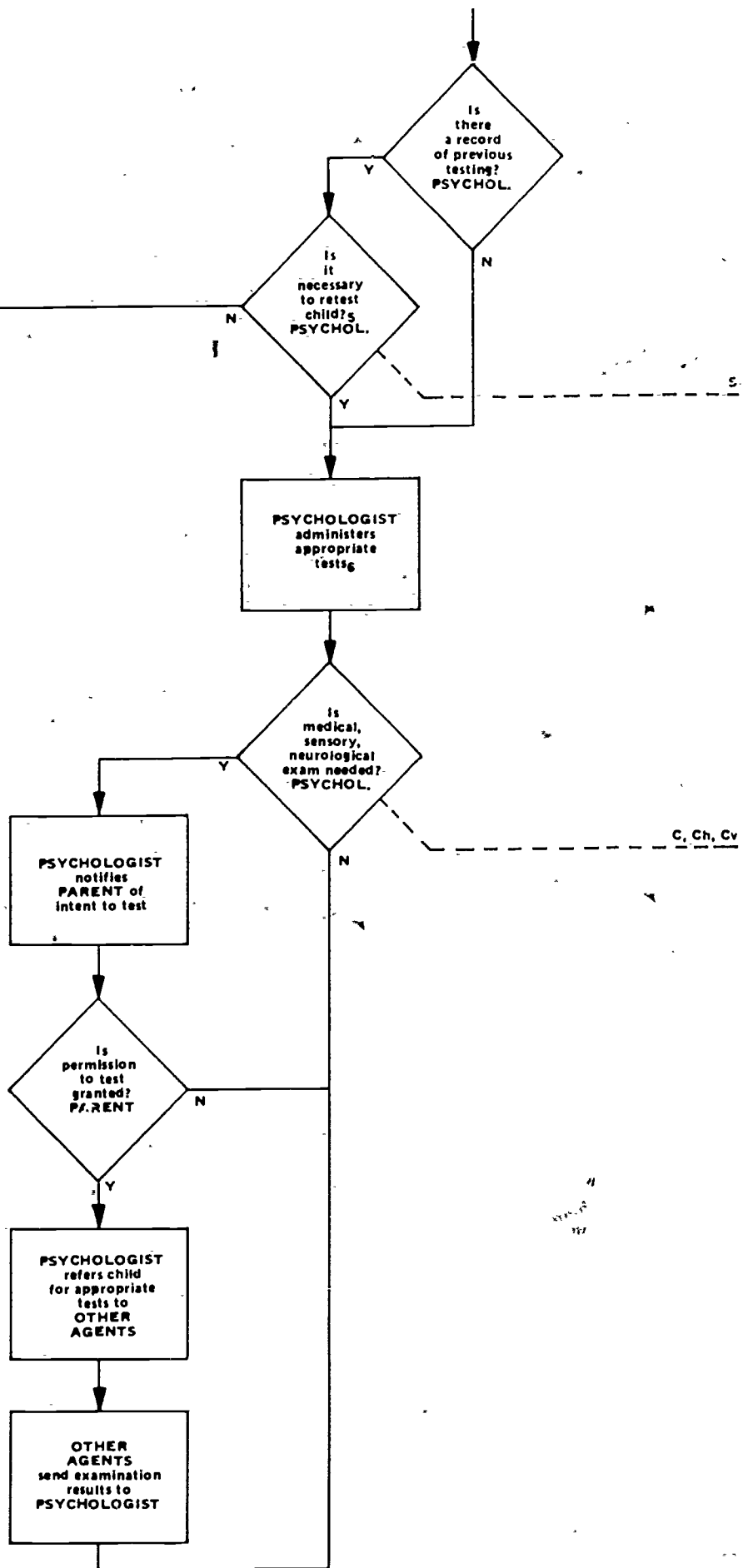
Each participant receives work sheets, process notes, recommendations, with listing of materials, etc.; Teacher is given materials to work with.

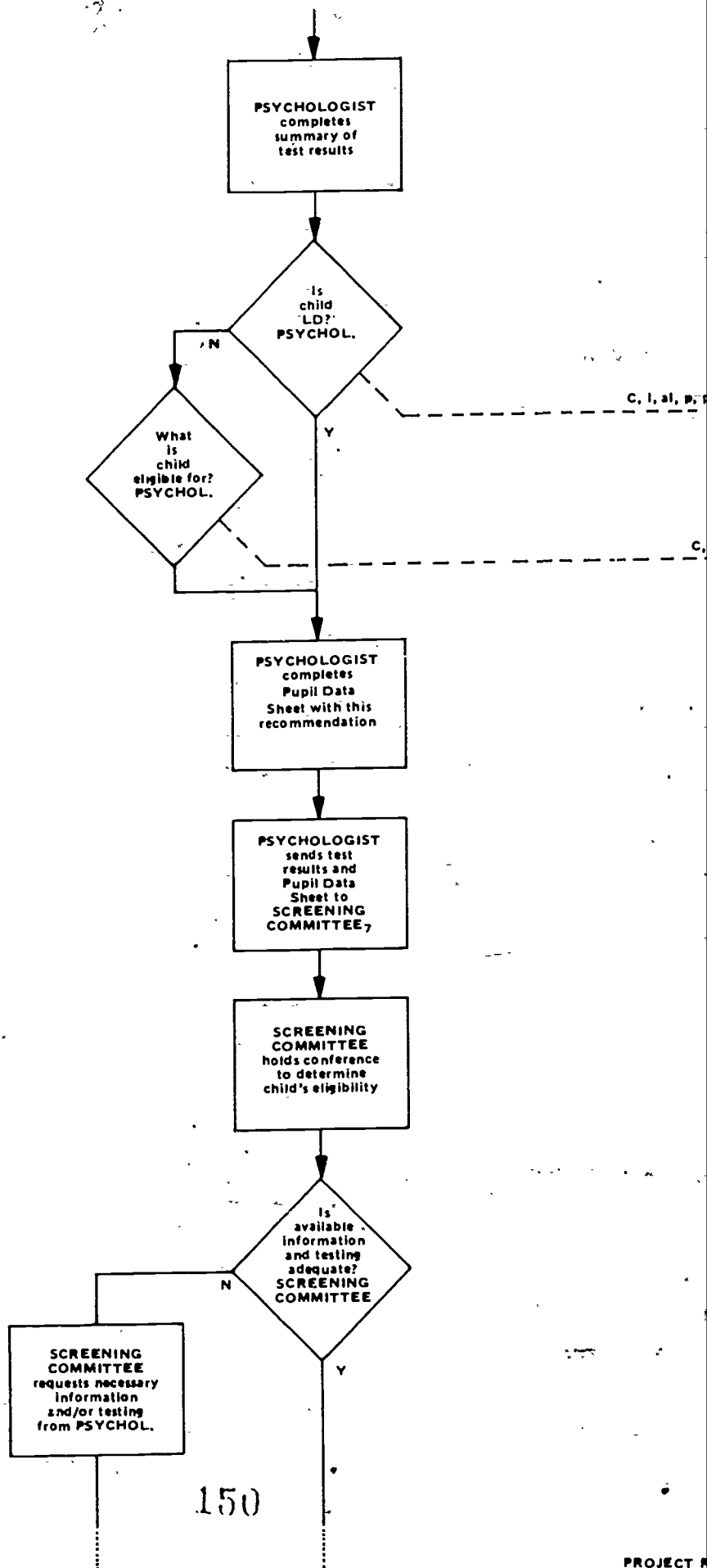
16. The precise criteria for designation as LD are unknown; however, the assumption is that is the child gets this far, he needs help; thus, the emphasis is on establishing a profile of skill and ability levels to which remediation (consultative) will be addressed.
17. (Level III). This indicates that Teacher cannot receive LD Diagnostic Center Diagnostic-Consultative Process - Level III; however, Level I and II processes are available.

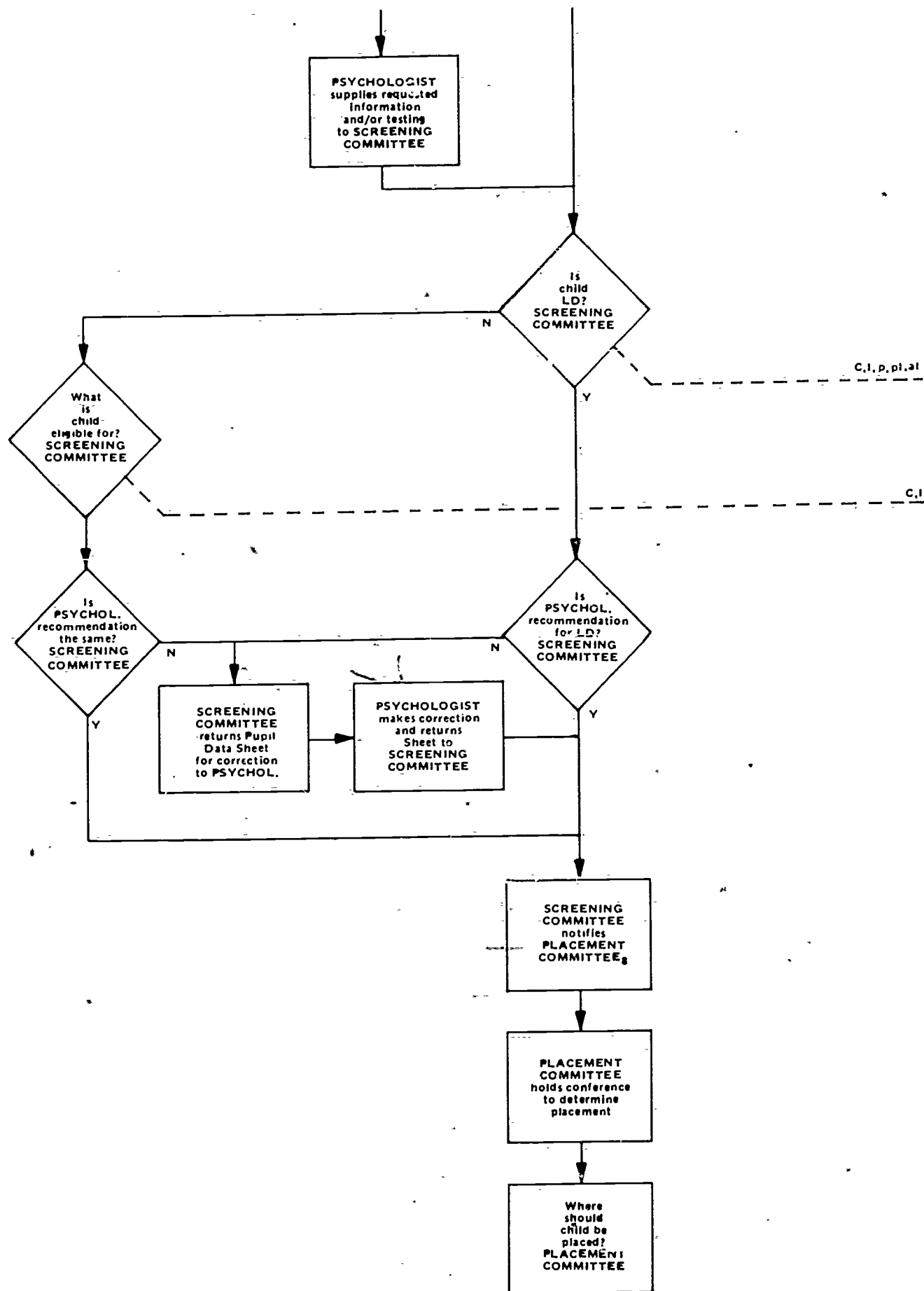


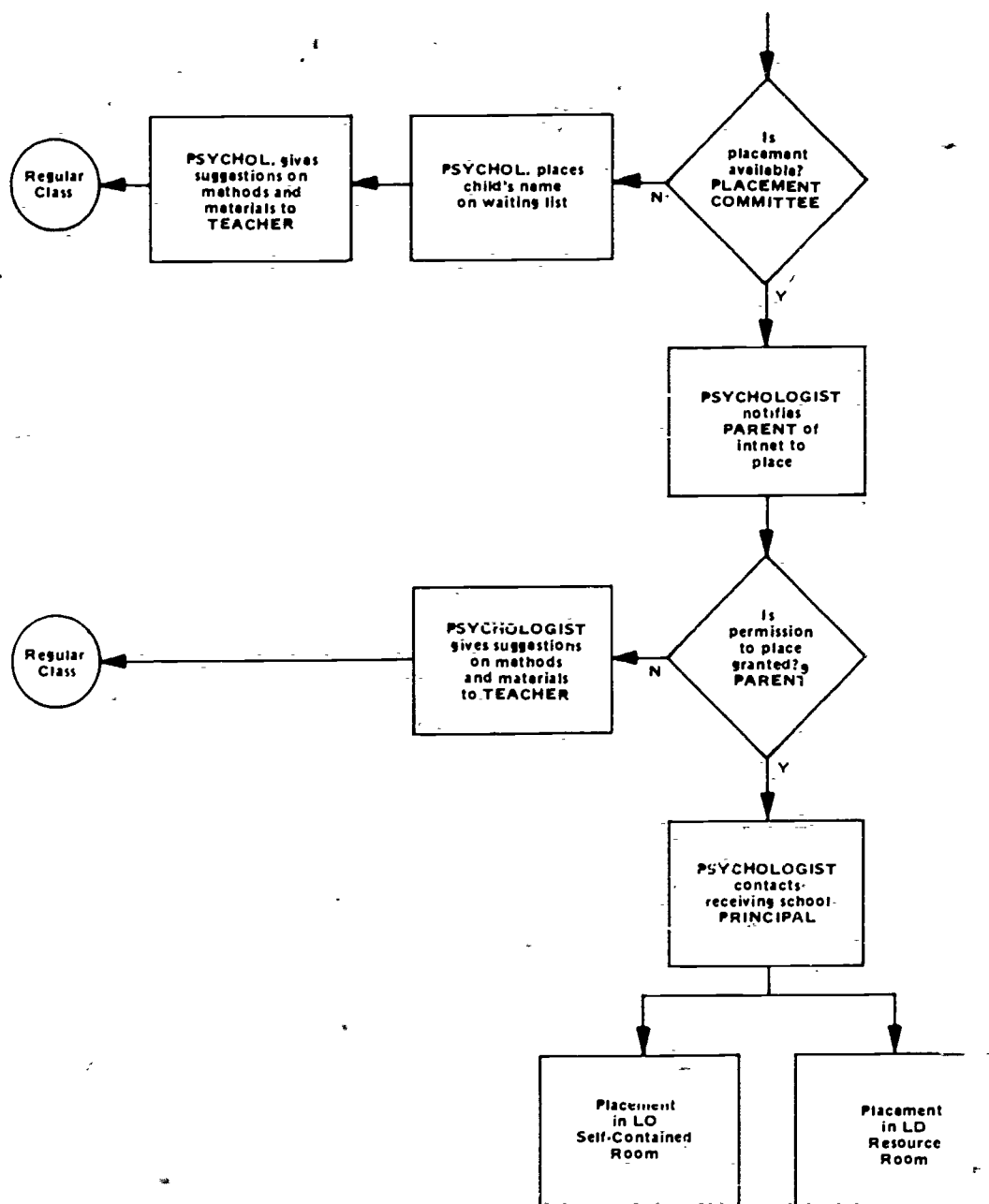


Regular
Class









I. GENERAL INFORMATION

1. Project Code Letter: R
2. Delivery System for Intervention: LD Resource Room (Grades 1-7)
LD Self-Contained Room
3. Initial Entry: Referral (Teacher/Parent/other Agents)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent
Other Agent
Teacher
Principal
Psychologist
Screening Committee (This committee serves on a regional basis and is set up by the State Department Office of Special Education. Members of the committee are not known).
 - b) Constraining decisions: Principal
Parent
Psychologist
Screening Committee (This committee serves on a regional basis and is set up by the State Department Office of Special Education. Members of the committee are not known).

Placement Committee (The Placement Committee is the Special Education Department of the local district. Who specifically serves on this Committee, other than the Psychologist, is unknown).

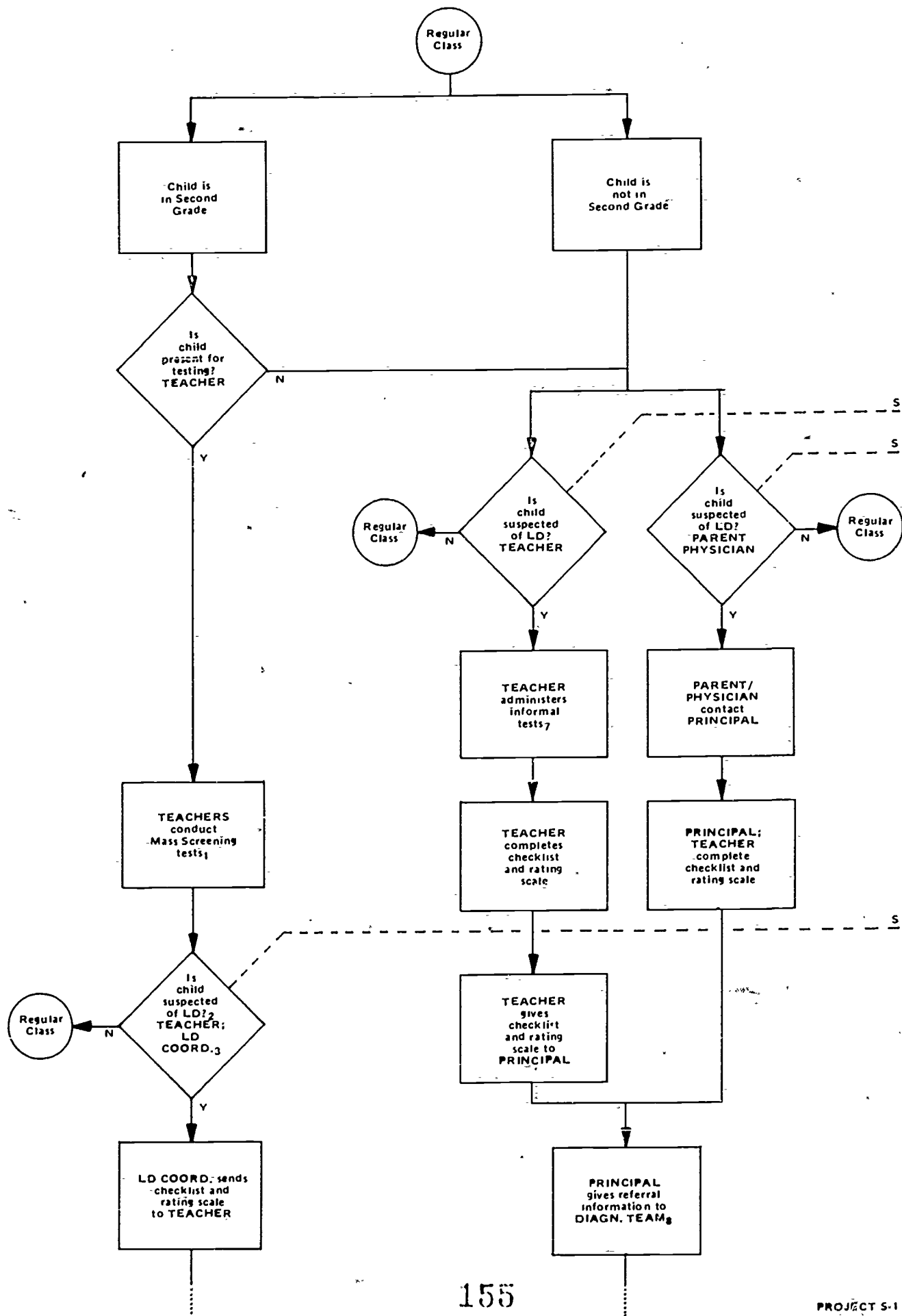
II. SPECIAL NOTATIONS

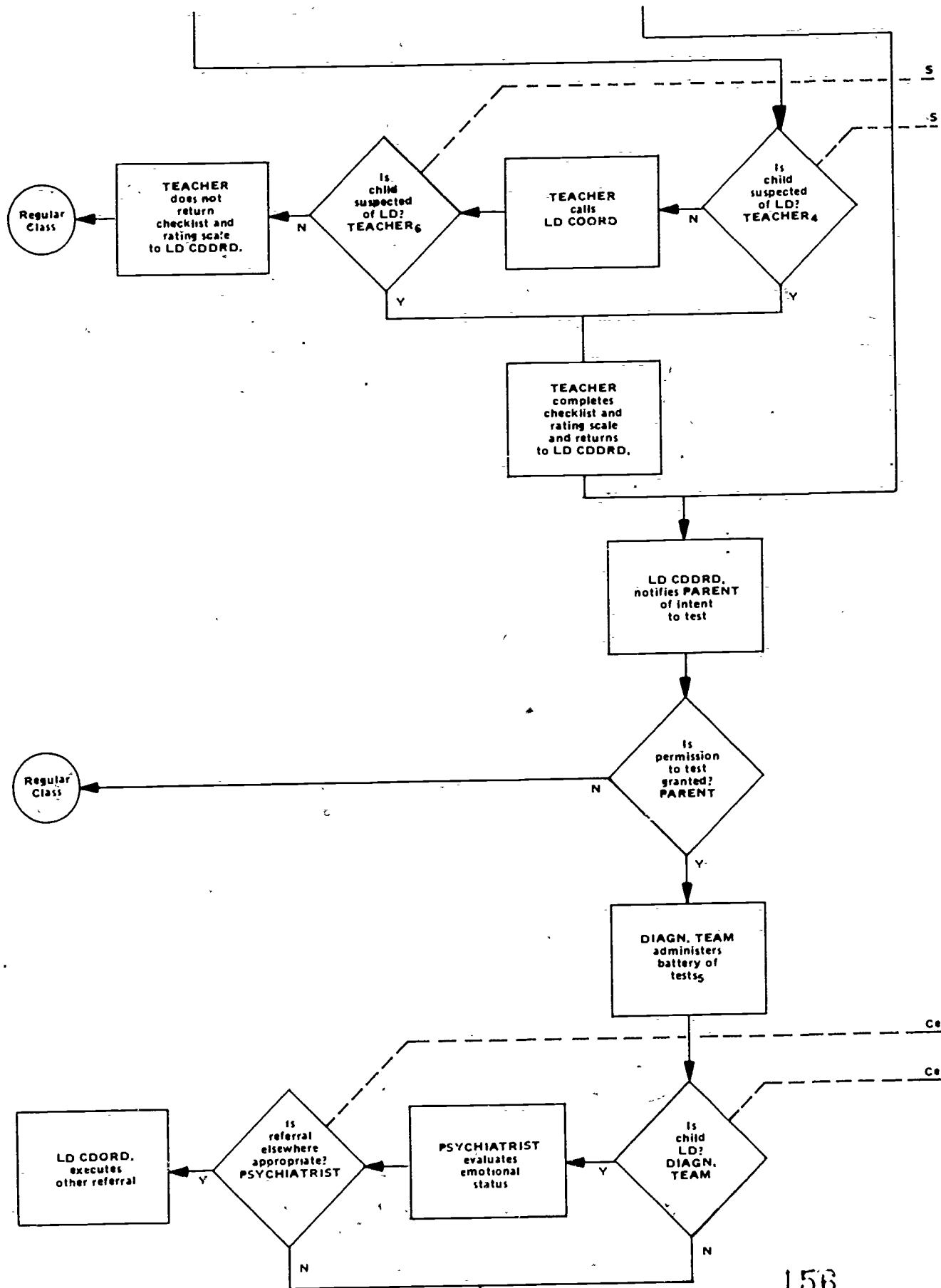
(footnotes apply to notations on flow-chart)

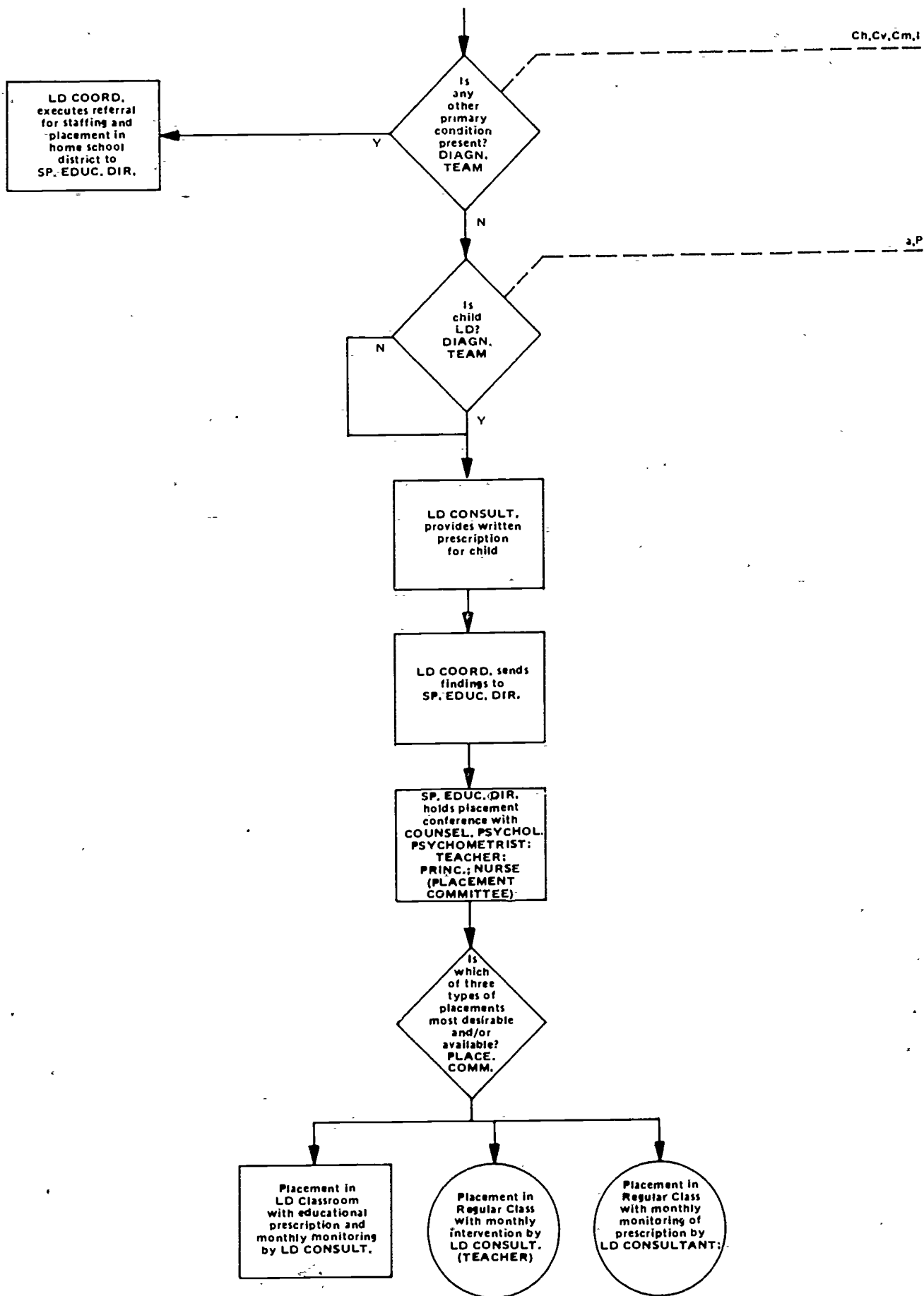
1. This is considered a very important question in this project because it serves to greatly reduce the number of referrals sent on to the project psychologist for testing. It should be noted that the question is practical rather than rhetorical, since there are considerable resources available within the school, including a remedial reading program, a language development program, and Title I Resource Teachers. The project director states: "This is one reason we decided to do it this way, because earlier we had just been taking referrals and we had too many referrals, and they just weren't very well thought through."
2. This would generally involve special education personnel, but might conceivably include the counselor or social worker.
3. Principal, teacher, and parent attend conference, and also a special education person if one is available in school building.

4. Parent forms include a permission-to-test form and a family information form.
5. If test scores are old, psychologist may decide that new testing is needed. On the other hand, this may be a child who was previously tested and found to be EMR and whose parents refused to place him there, searching instead for a different program.
6. Required tests: WISC, WRAT, Bender, Draw-A-Person.
Optional tests: ITPA, Vallett's Psychoeducational Inventory of Basic Learning Abilities, Gray Oral Reading Test, Frostig, Wepman.
In addition, the decision may be made to get additional background information from parent (developmental history).
7. This committee serves on a regional basis and is set up by the State Department Office of Special Education. Members of the committee are not known. The role of this committee is simply to confirm or reject the psychologist's decision. The final decision as to eligibility rests with this committee.
8. The Placement Committee is the Special Education Department of the local district. Who specifically serves on this committee, other than the Psychologist, is unknown. The single role of the Committee is to find and arrange placement for eligible children (whatever the eligibility).
9. A reason for refusal might be transportation problems, if the child is to be placed in another school.

Project R-8







I. GENERAL INFORMATION

1. Project Code Letter: S
2. Delivery System for Intervention: LD Consultative (Grades K-6)
3. Initial Entry: Mass Screening (Analysis of Learning Potential and Metropolitan Achievement)

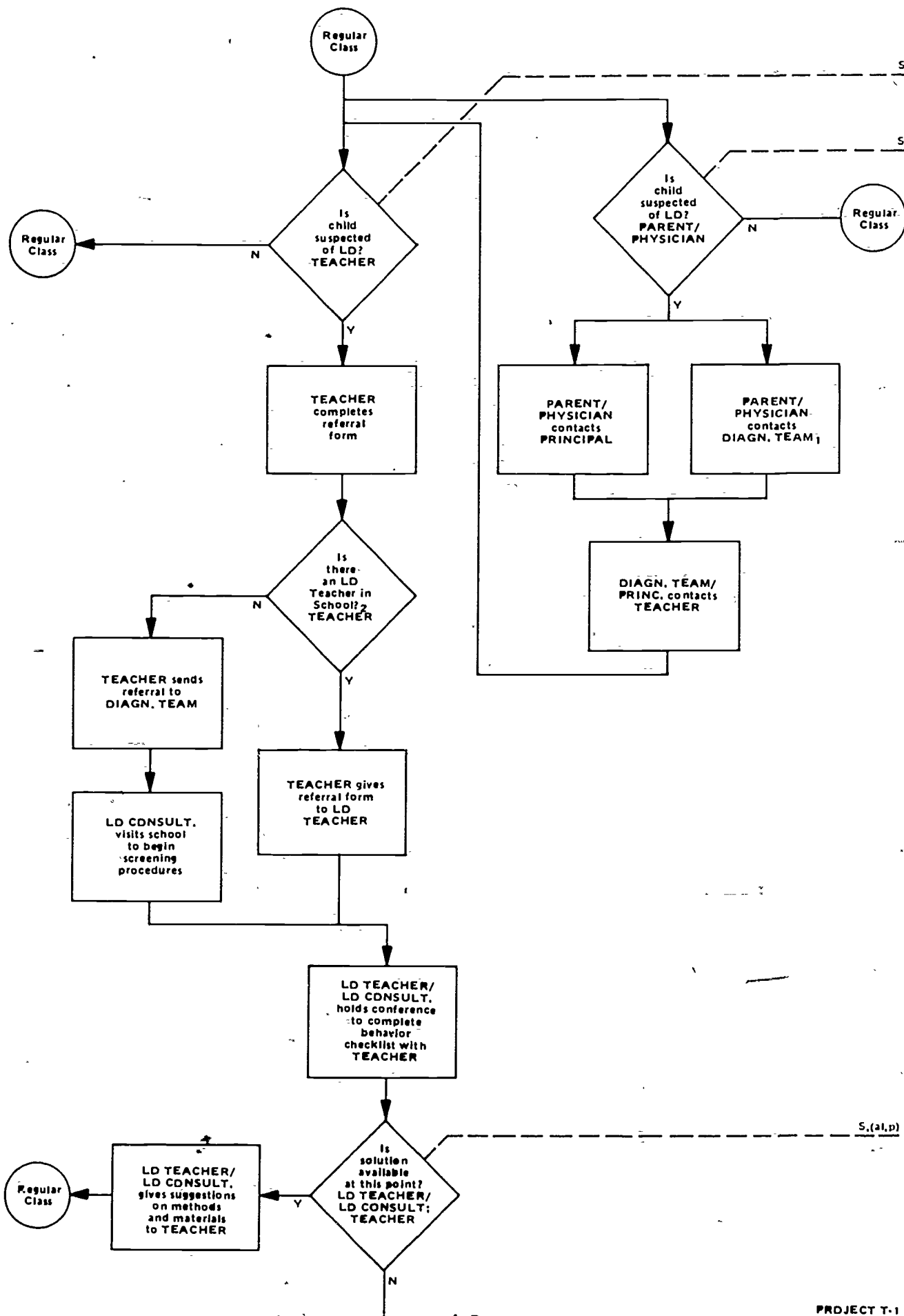
Referral (Teacher/Parent/Physician)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher Diagnostic Team (Counseling
LD Coordinator Psychologist, Psychometrist,
Parent Educational Specialist,
Physician • LD Consultant, Psychiatrist)
 - b) Constraining decisions: Teacher
Parent
Placement Committee (Special Education Director,
Counseling Psychologist,
Psychometrist, Teacher,
Principal, Nurse)

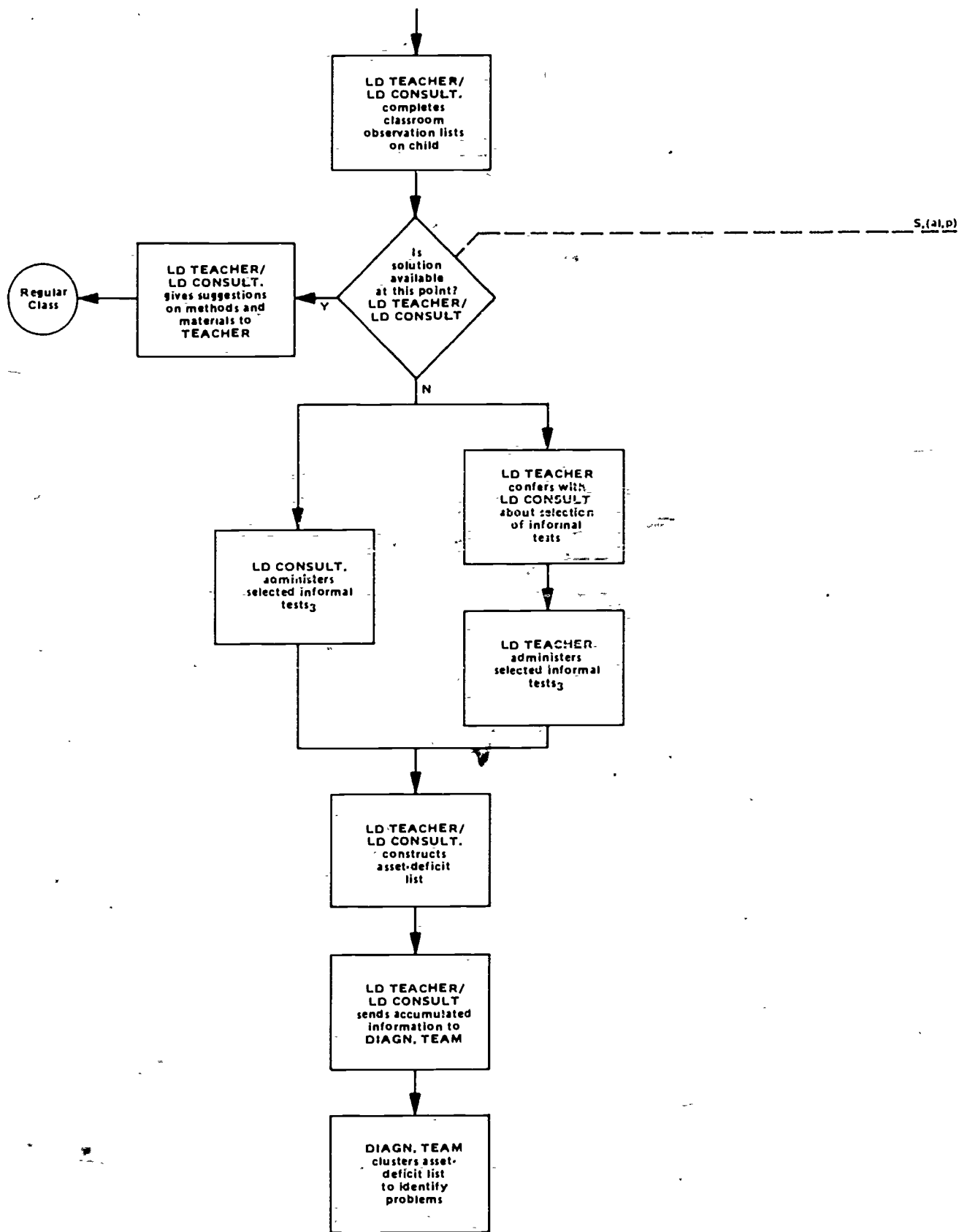
II. SPECIAL NOTATIONS

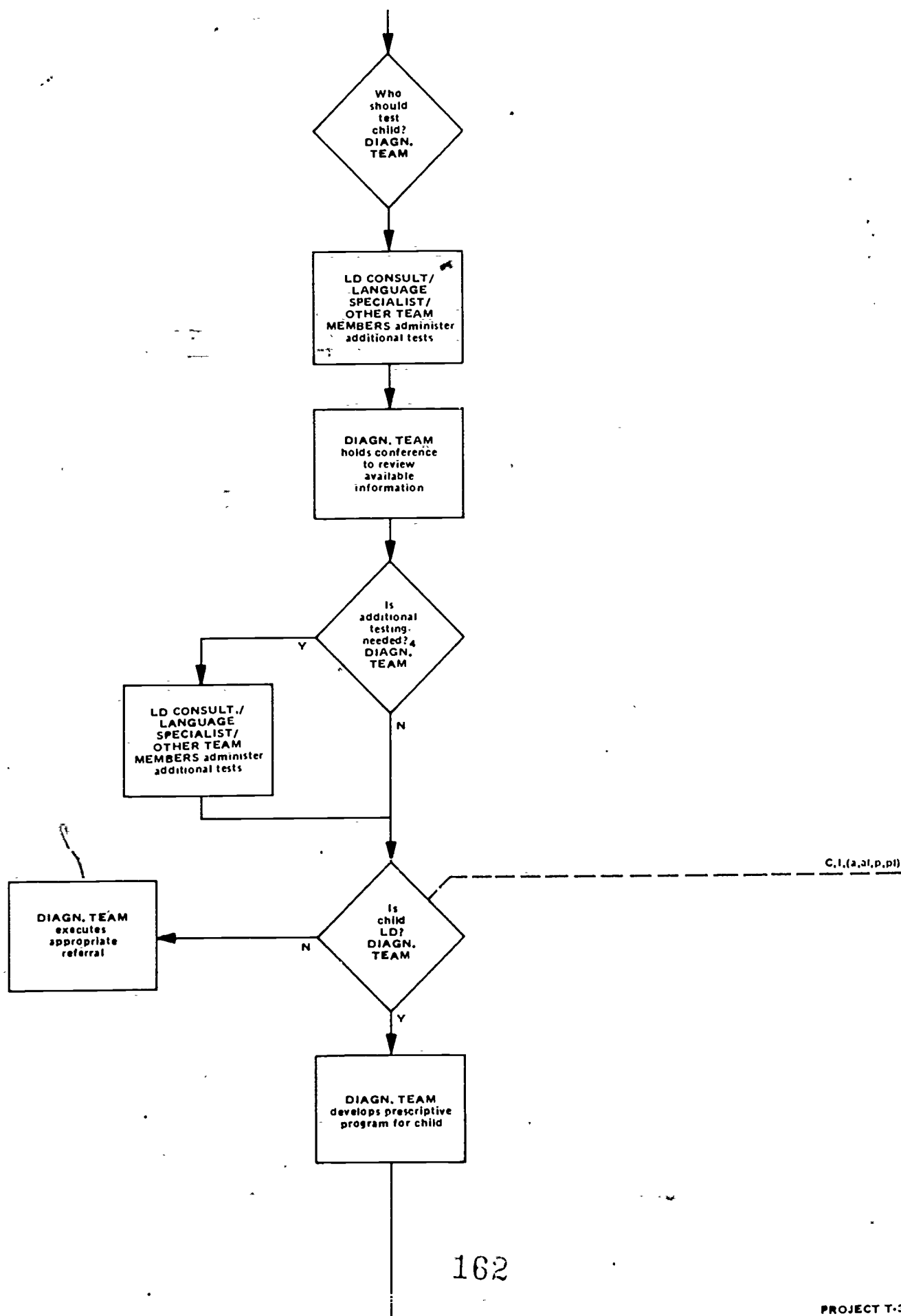
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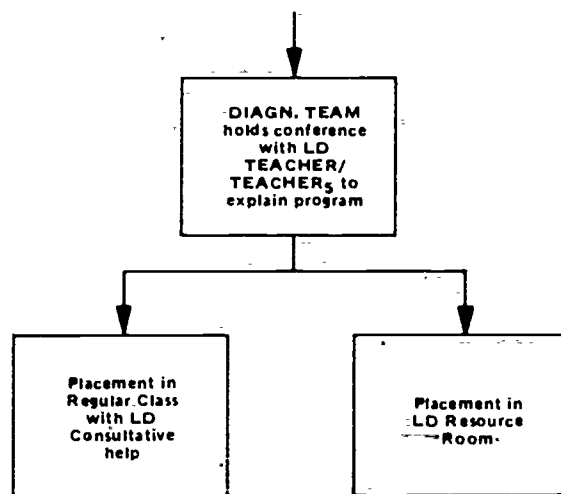
1. Mass Screening includes Analysis of Learning Potential Test; Metropolitan Achievement Tests; tests given a week apart.
2. Child is suspect if he has discrepancy in any score six months below expectancy.
3. LD Coordinator is Title VI-G Project local Director; the decision here is solely based on test results given by Teacher to LD Coordinator.
4. This decision really says "Does the teacher agree with the findings of suspected LD?"
5. Diagnostic battery includes WISC, Draw-A-Person, PPVT, Purdue, ITPA, CAT, California Personality, Sentence Completion, Telebinocular, Frostig, Bender, Audiometric Test, Memory-for-Design.
6. The phone call is for the purpose of the teacher verifying the hi-risk rating from testing; if the teacher is still not in agreement that the child is hi-risk, after talking to the LD Coordinator, the child is not continued in the identification process.
7. These "informed" tests are taught in in-service and vary considerably - may include tests like VMI, Wepman, etc.
8. Diagnostic Team includes Counseling Psychologist, Psychometrist,

Educational Specialist (Communication; Media, Materials, Methods Specialist (M & M). We will refer to the latter as the LD Consultant. A Psychiatrist also sits in on appropriate cases.









I. GENERAL INFORMATION

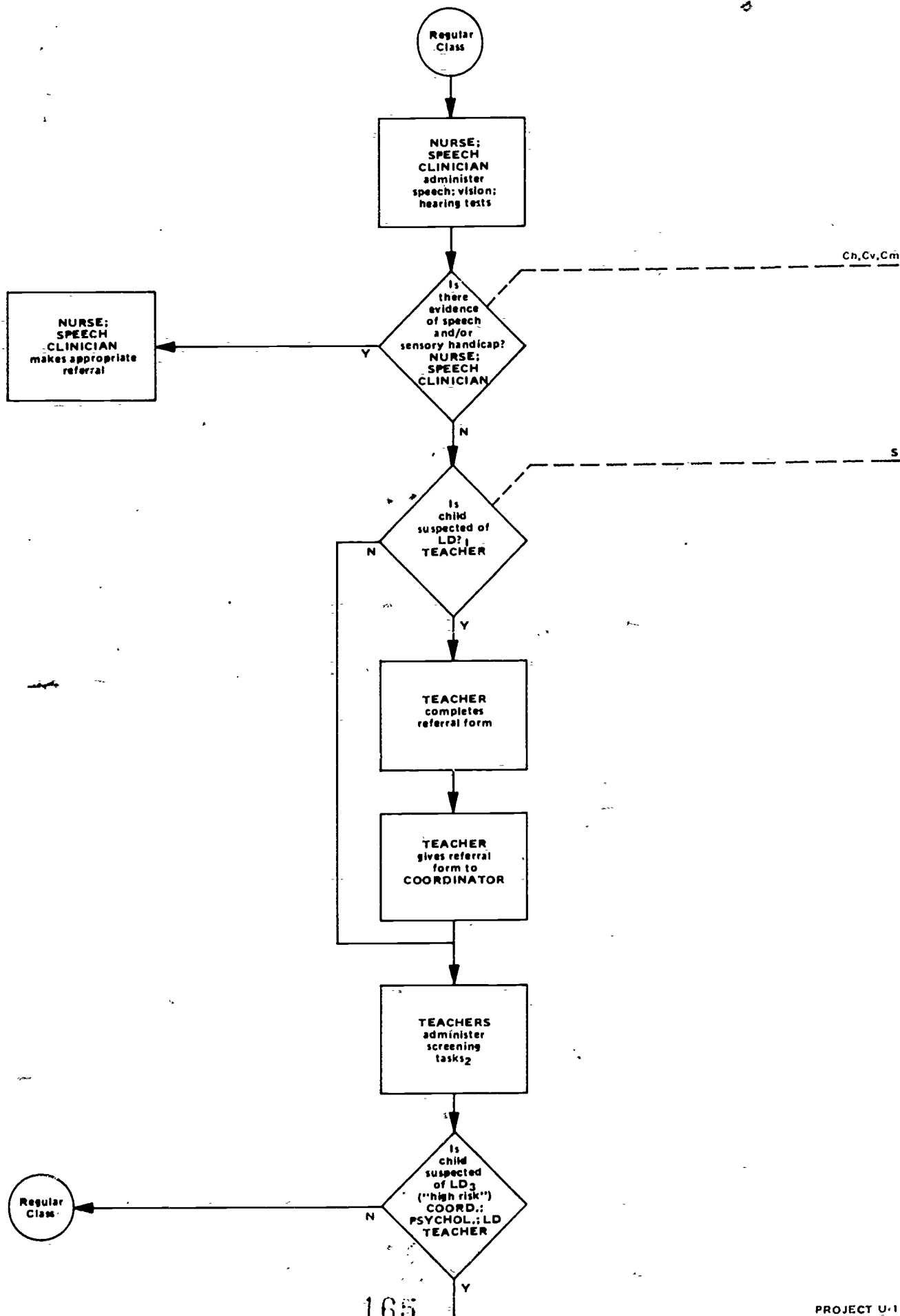
1. Project Code Letter: T
2. Delivery System for Intervention: LD Consultative (Grades K-6)
LD Resource Room
3. Initial Entry: Referral (Teacher/Parent/Physician)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Parent
Physician
LD Teacher
LD Consultant
Diagnostic Team
 - b) Constraining decisions: Diagnostic Team (Language Specialist, Psychologist)
LD Consultant and others not known

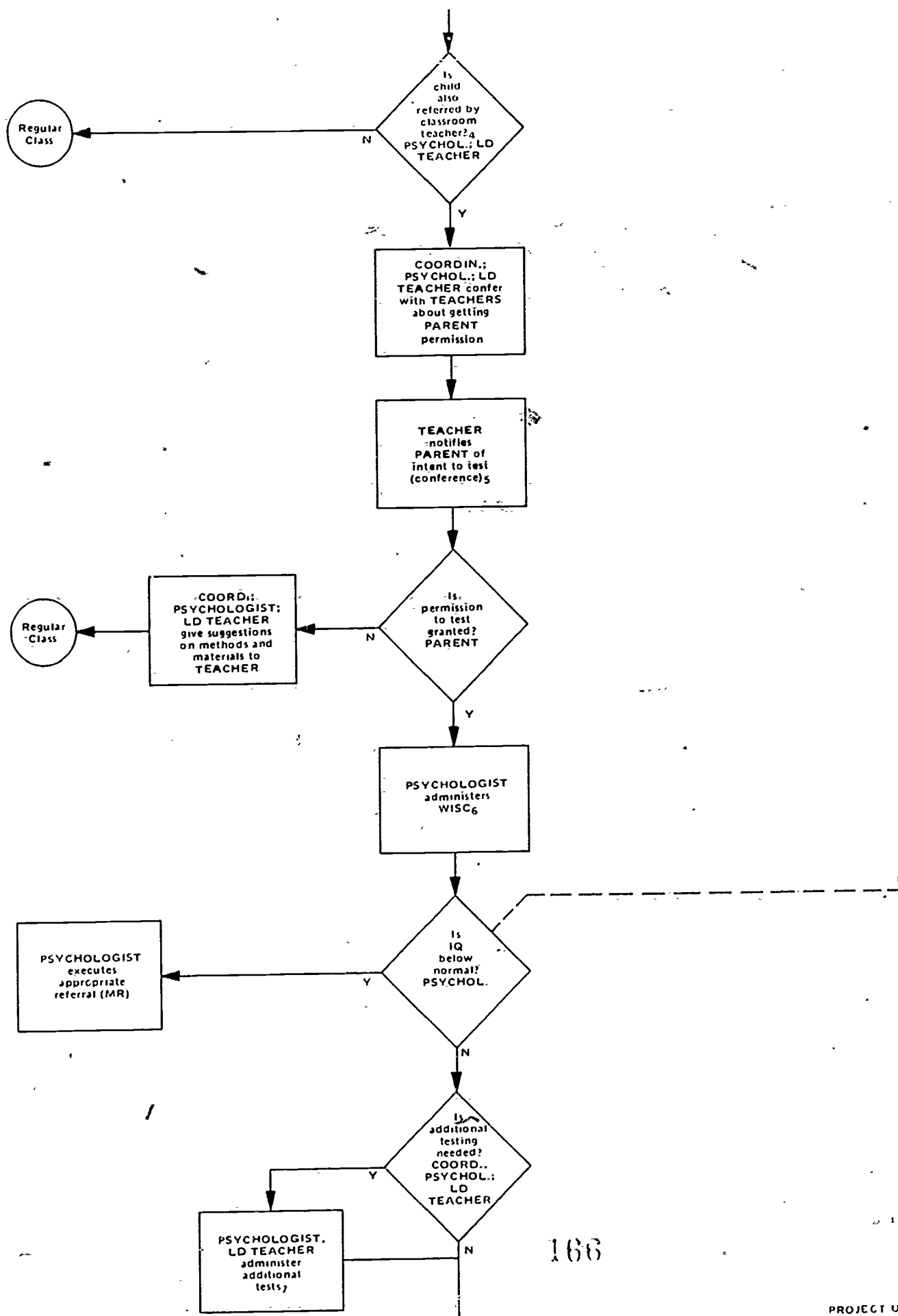
II. SPECIAL NOTATIONS

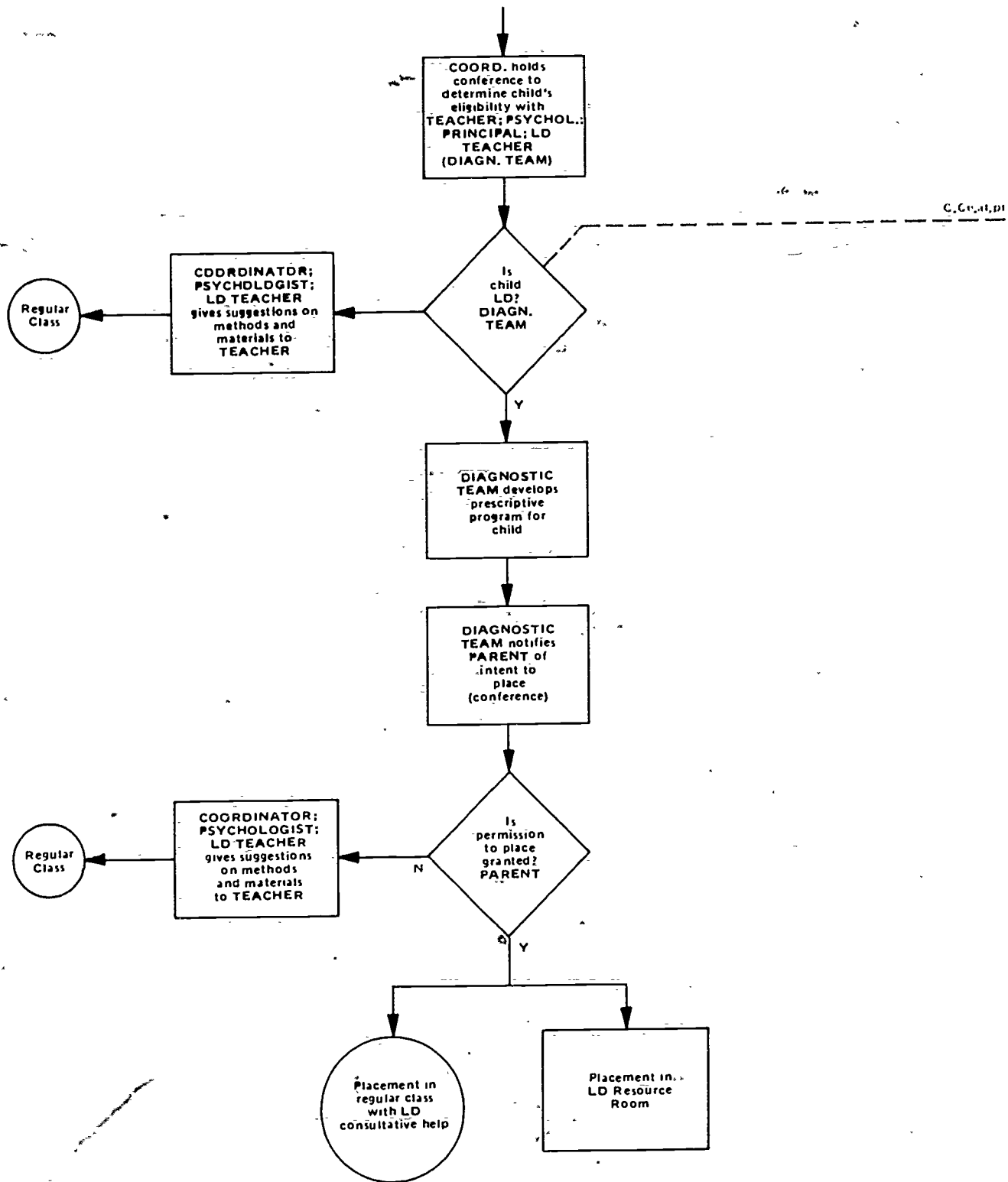
(footnotes apply to notations on flow-chart)

1. The team operates in an outside agency serving several school districts for assessment and consultative purposes. It includes a Language Specialist, Psychologist, LD Consultant and others.
2. The standard procedure is for teacher to give referral to LD Teacher in her building. This person completes preliminary screening before sending child to Diagnostic Center. On the other hand, in schools where there is no on-site LD Teachers, the teacher must refer directly to the center. In this case, the Center's LD Consultant must assume responsibility for the preliminary screening.
3. This may take place over a week's time. Tests may include Best Test, PIAT, Detroit, Peabody Picture Vocabulary, Weepman, and diagnostic teaching session.
4. This may involve further diagnostic teaching or formal testing (psychological educational).
5. This, of course, depends on whether there is an LD Teacher in the school. If so, the Team works through that person and not directly with the regular teacher.

Project T-5







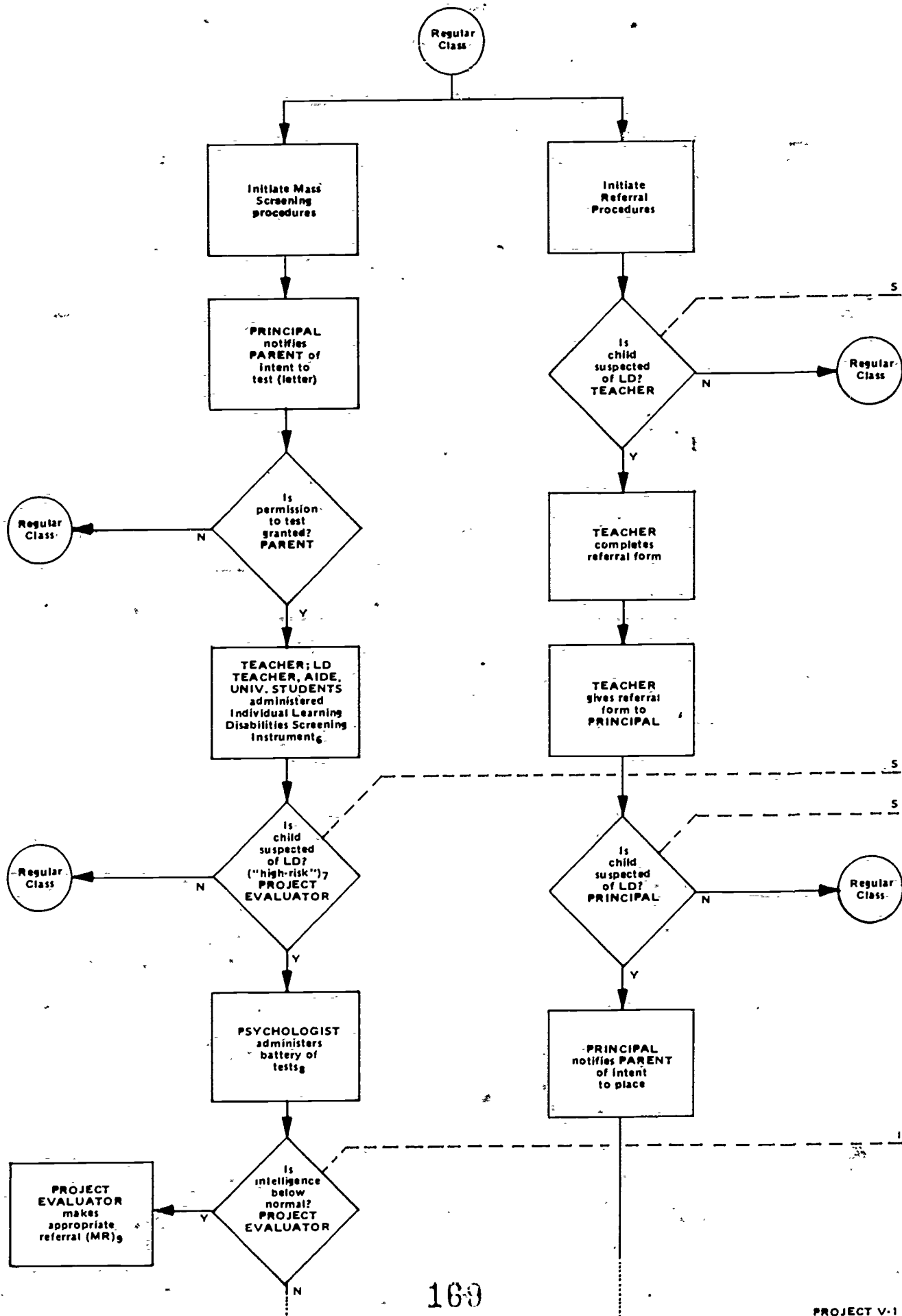
I. GENERAL INFORMATION

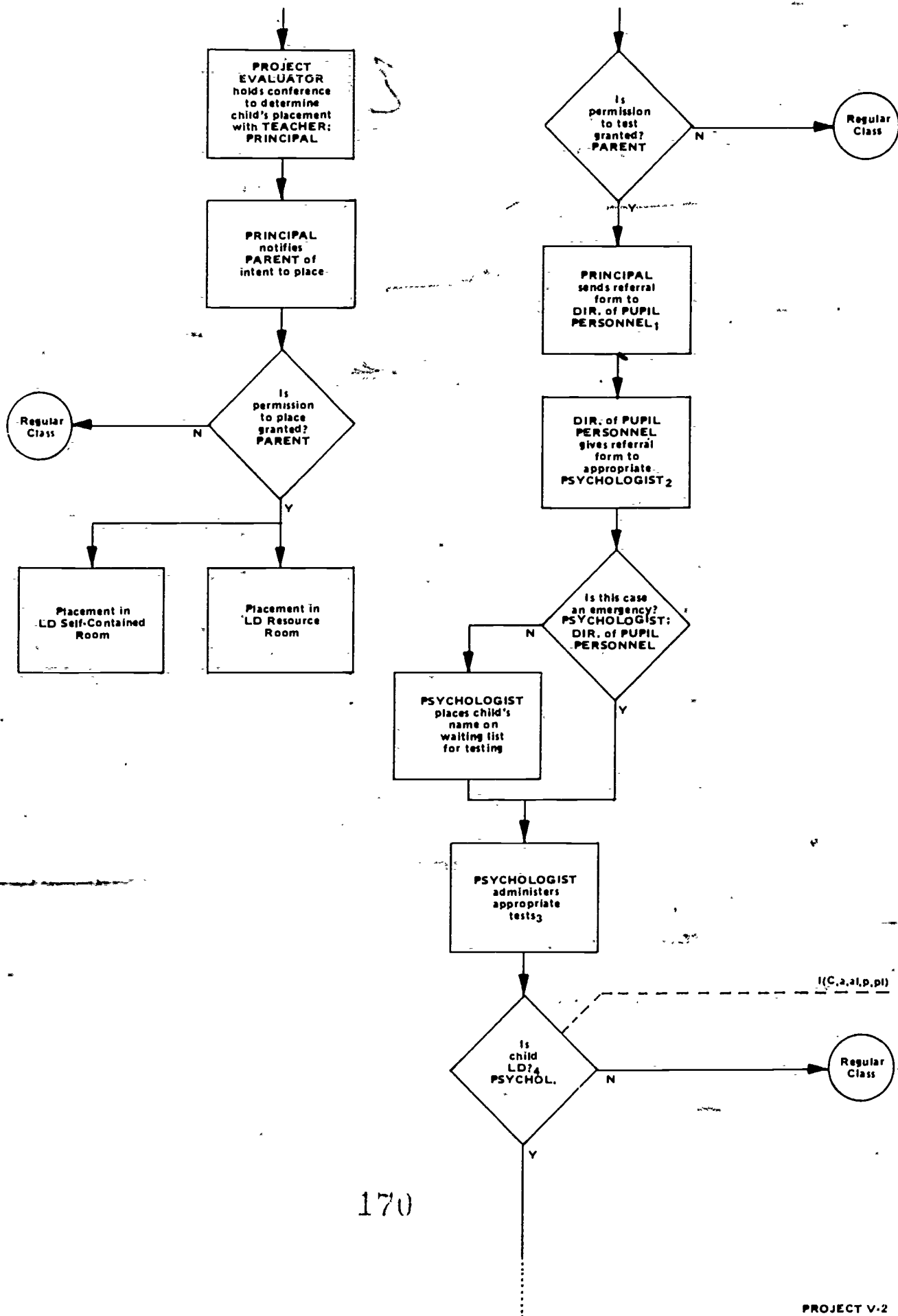
1. Project Code Letter: U
2. Delivery System for Intervention: LD Resource Room (Grades K-12)
LD Consultative
3. Initial Entry: Mass Screening (modified Kunzelman Screening Tests)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Speech Clinician
Nurse
Teacher
Coordinator
Psychologist
LD Teacher
Diagnostic Team (Coordinator,
Psychologist, LD Teacher,
Principal, Teacher)
 - b) Constraining decisions: Coordinator
Psychologist
LD Teacher
Parent

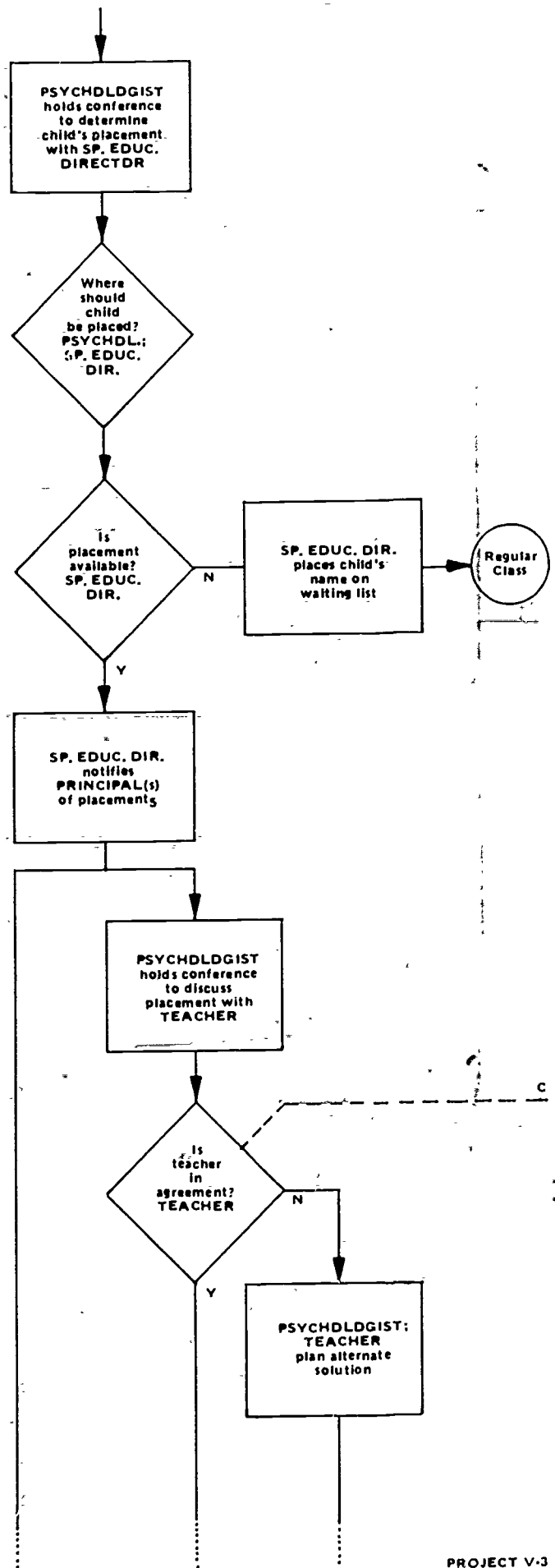
II. SPECIAL NOTATIONS.

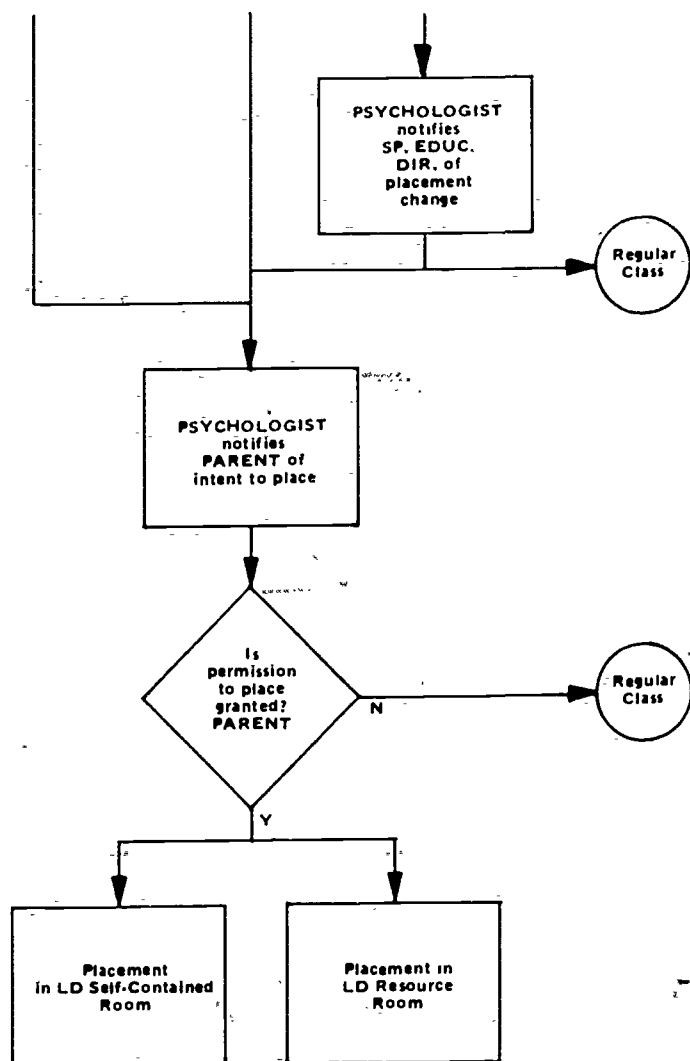
(footnotes apply to notations on flow-chart)

1. Teachers can refer at any time. However, the referral is only considered for the project if the child is also identified as high risk in the mass screening procedure. Thus, it is not shown as a possible first step.
2. The screening procedure used was an adaptation of the Kunzelman Screening Test, in which children did 6 tasks for one minute apiece each day for 10 days. In addition, the children did a word recognition task, an auditory discrimination task, and an auditory-memory task.
3. The criteria was flexible but basically children were selected who scored 50% below grade level (norm had been established) on 2 or more tasks.
4. The addition of this criteria further reduced the number of high-risk children, bringing that number to about 10% of the screened population, or about 3 children from each class.
5. At the classroom teacher's request, Psychologist, LD Teacher, LD Coordinator, or Principal would attend.
6. Testing was done in order of "teachers who screamed the loudest" or "children who seemed to be having the most difficulty." Testing all the children took 3 months.
7. Possible tests include Bender, ITPA, WRAT, Wepman, Purdue Motor Survey, various academic tests, etc. The amount of testing depends on how quickly they discover what is wrong with the child.









I. GENERAL INFORMATION

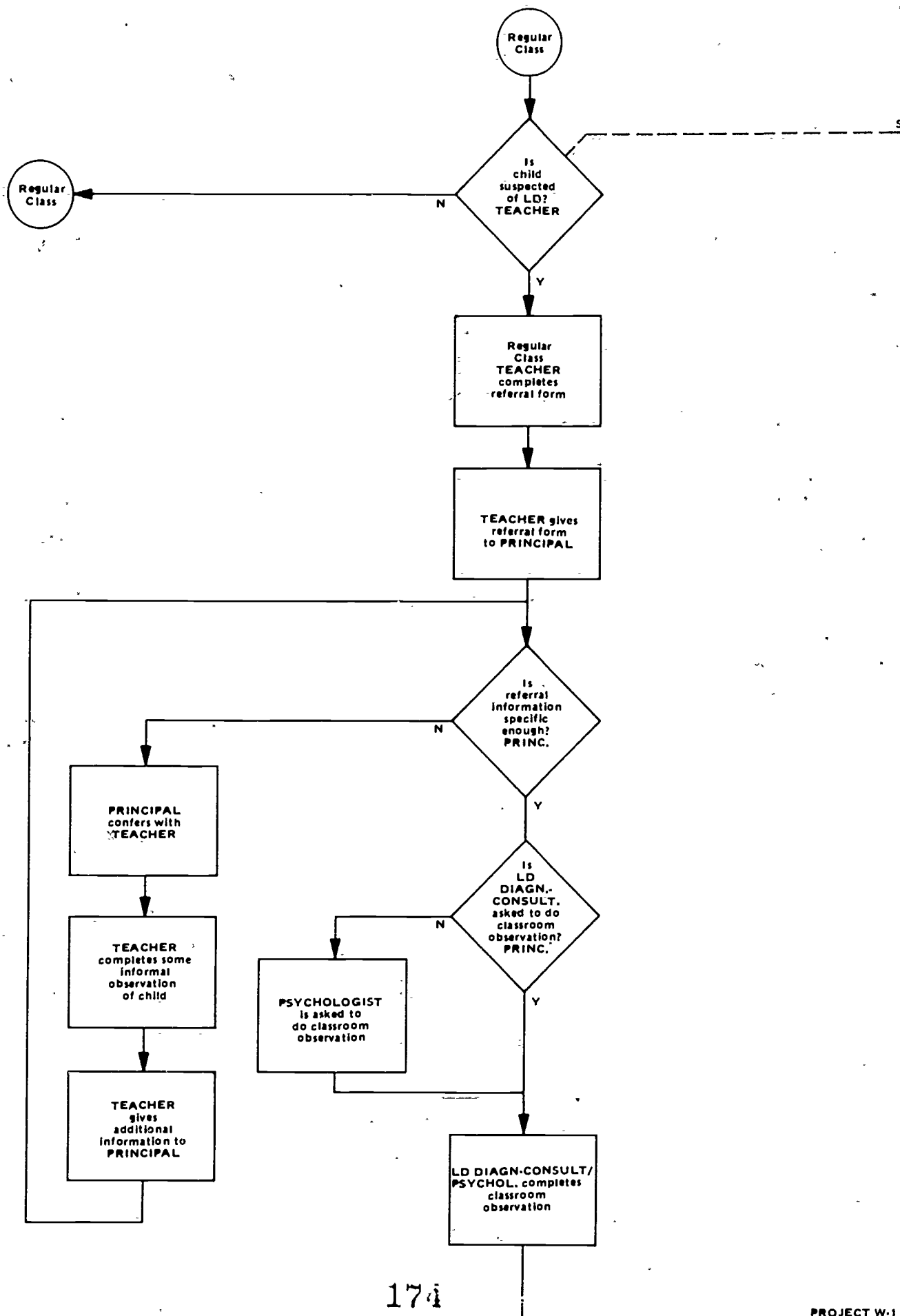
1. Project Code Letter: V
2. Delivery System for Intervention: LD Resource Room (Grades K-3)
LD Self-contained
Mass Screening (Individual Learning
Disabilities Screening
Instrument)
3. Initial Entry: Referral (Teacher).
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher Special Education Director
Principal Project Evaluator
Psychologist
 - b) Constraining decisions: Parent
Teacher

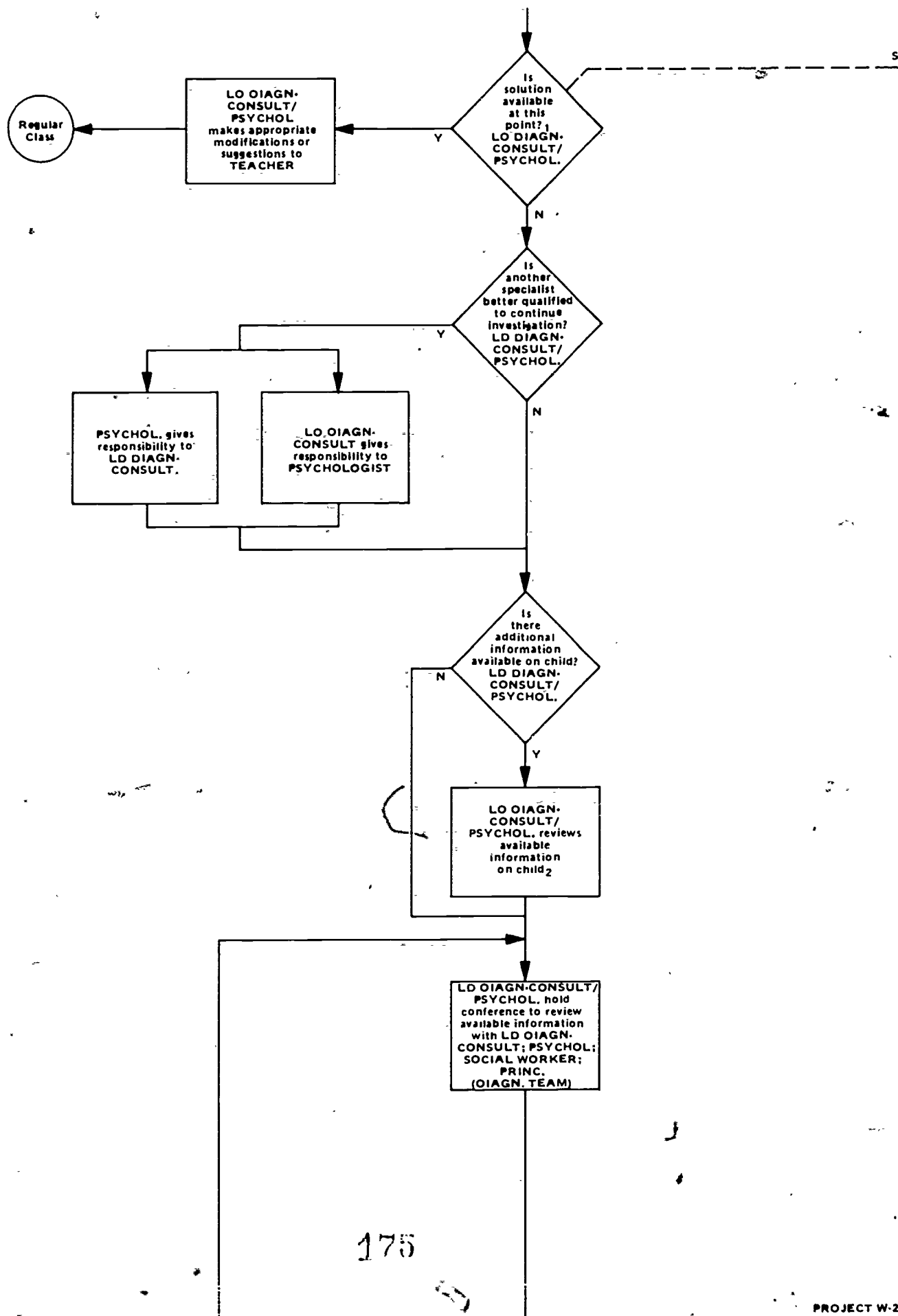
II. SPECIAL NOTATIONS

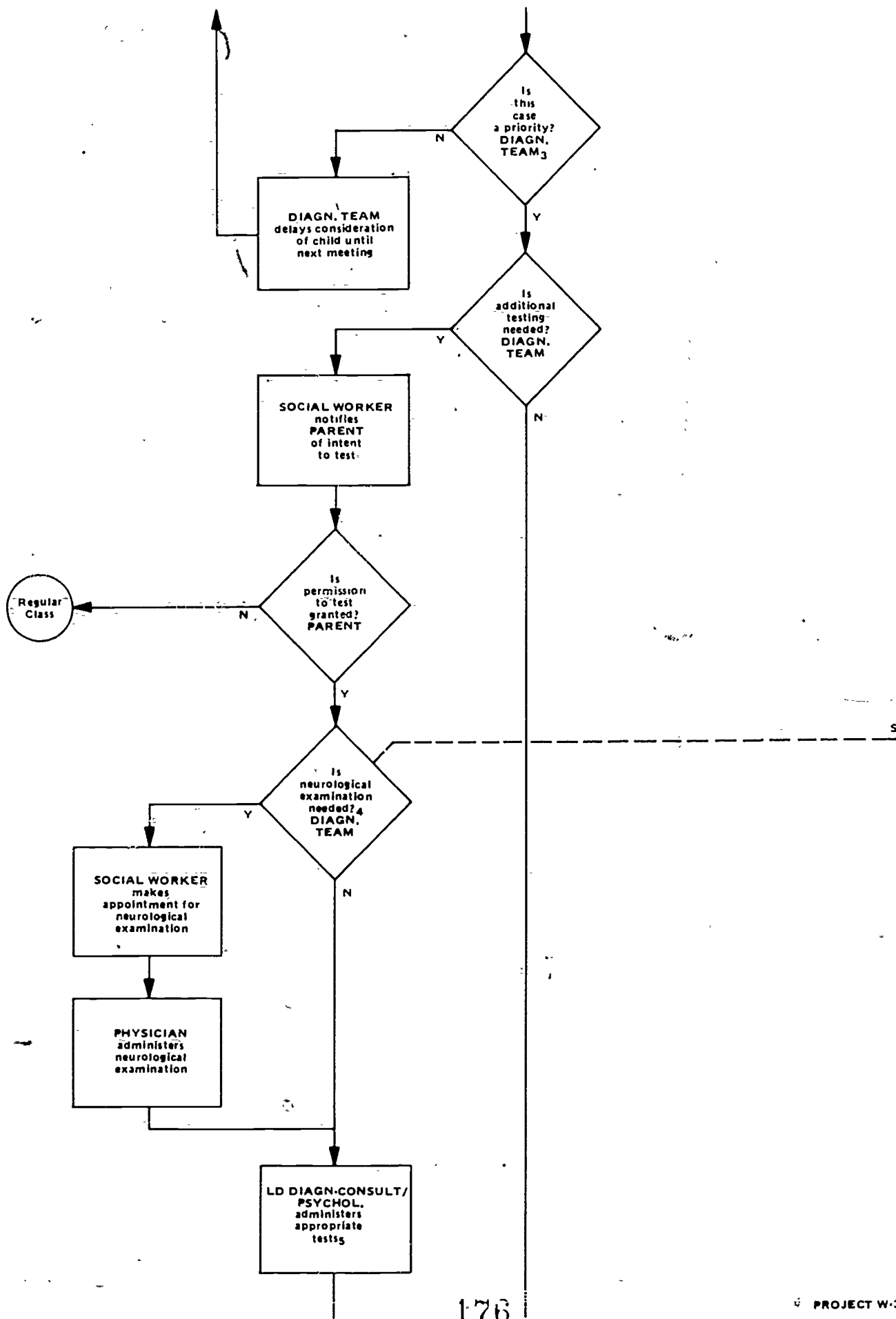
(footnotes apply to notations on flow-chart)

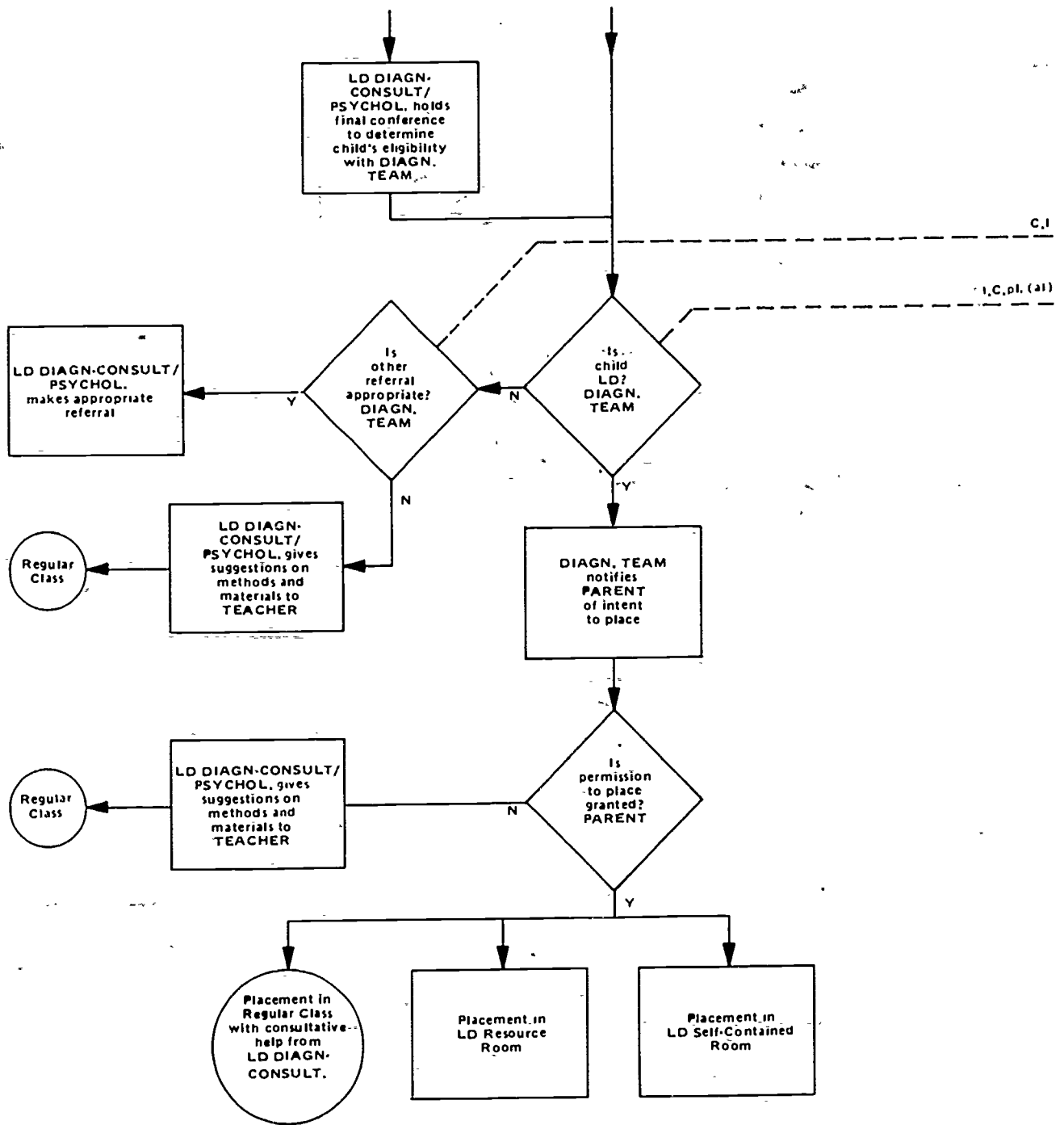
1. It was stated in the interview that the referral was sent to "guidance and counseling." We assume that the Director of Pupil Personnel functions as the administrator of that division.
2. Each Psychologist is responsible for several schools. The referral would go to the Psychologist who covers the child's school.
3. Specific tests are not known, but there is no standard battery; the specific tests chosen are the Psychologist's decision.
4. Criteria used to determine eligibility at this point are not known.
5. A child may be moved to another school, in which case both the sending and receiving Principal would be notified.
6. Copyright 1970 by Meier, Cazier, Giles, and published by Learning Pathways, Inc.
7. Evaluator followed cut-off score established by the instrument, with no apparent flexibility.
8. Psychologist gives WISC and ITPA, but other tests used are not known.
9. There were no referrals to MR this year, which probably reflects the skewed population of the district.

Project V-5









I. GENERAL INFORMATION

1. Project Code Letter: W
2. Delivery System for Intervention: LD Consultative; (Grades K-3)
LD Resource Room; LD Self-Contained
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
LD Diagnostician-Consultant
Psychologist
Diagnostic Team (LD Diagnostic-Consultant;
Psychologist, Social Worker
Principal)
 - b) Contraining decisions: Principal
LD Diagnostic-Consultant
Psychologist
Diagnostic Team (LD Diagnostic-Consultant,
Psychologist, Social Worker
Principal)

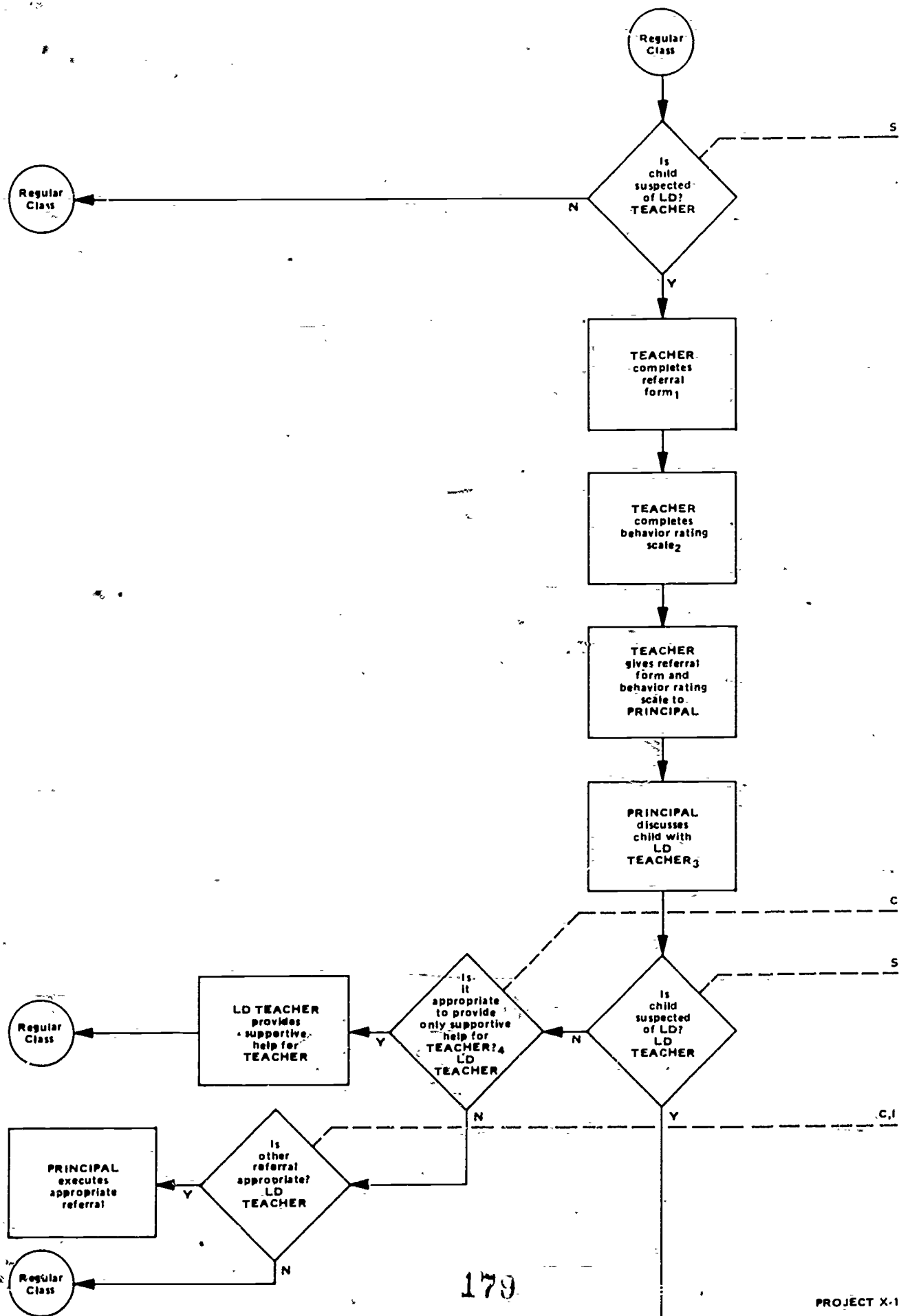
Parent

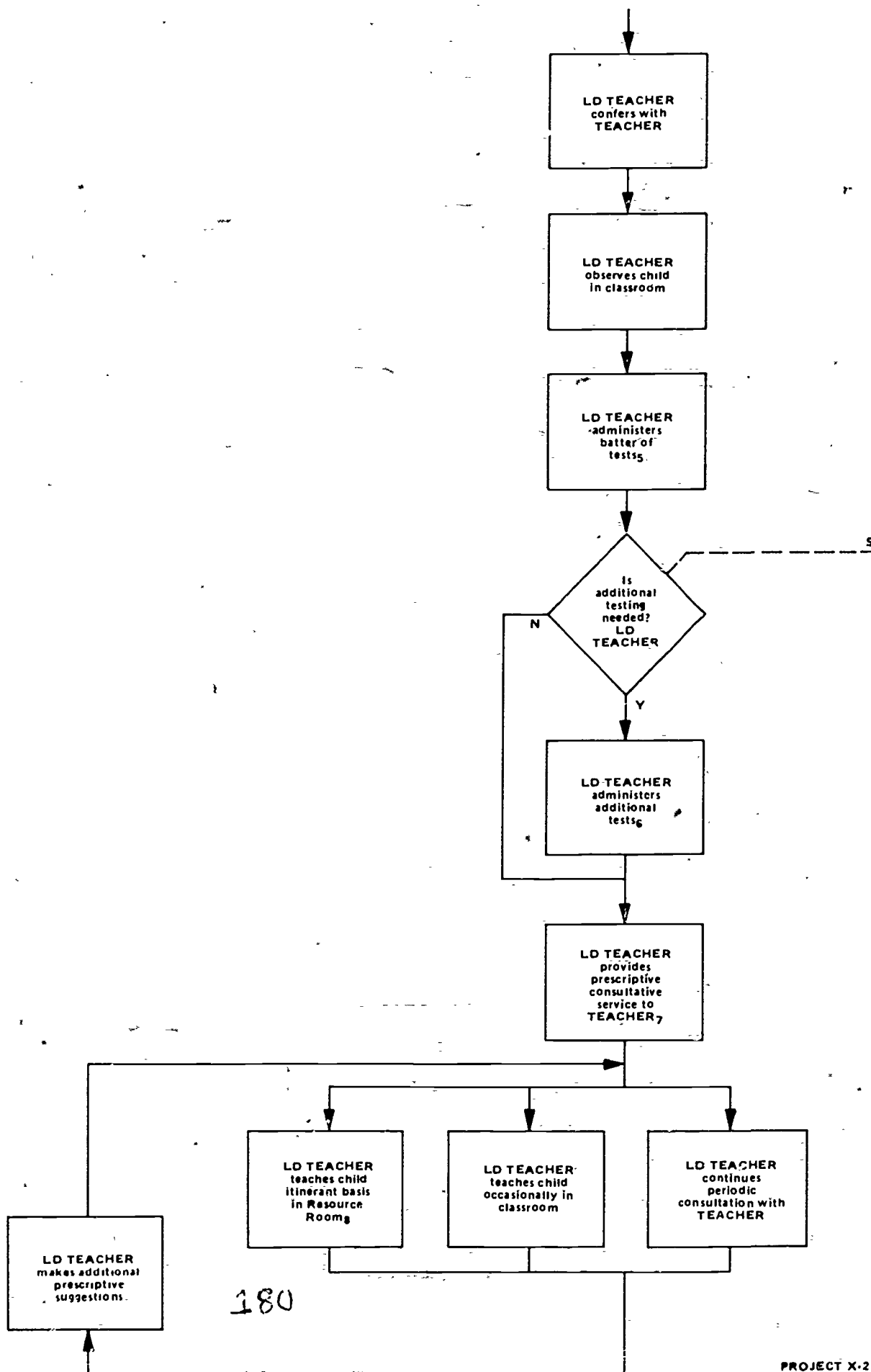
II. SPECIAL NOTATIONS

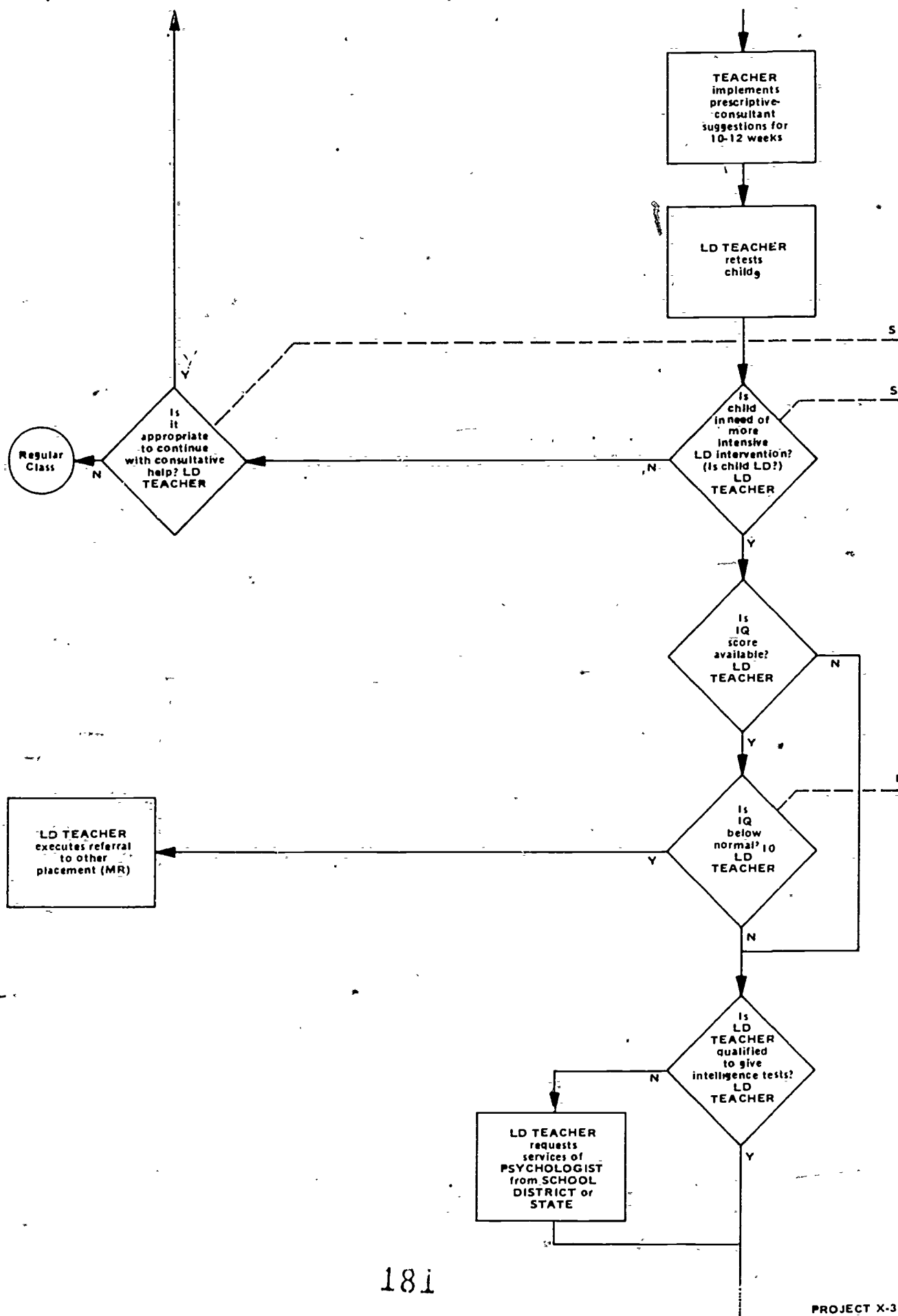
(footnotes apply to notations on flow-chart)

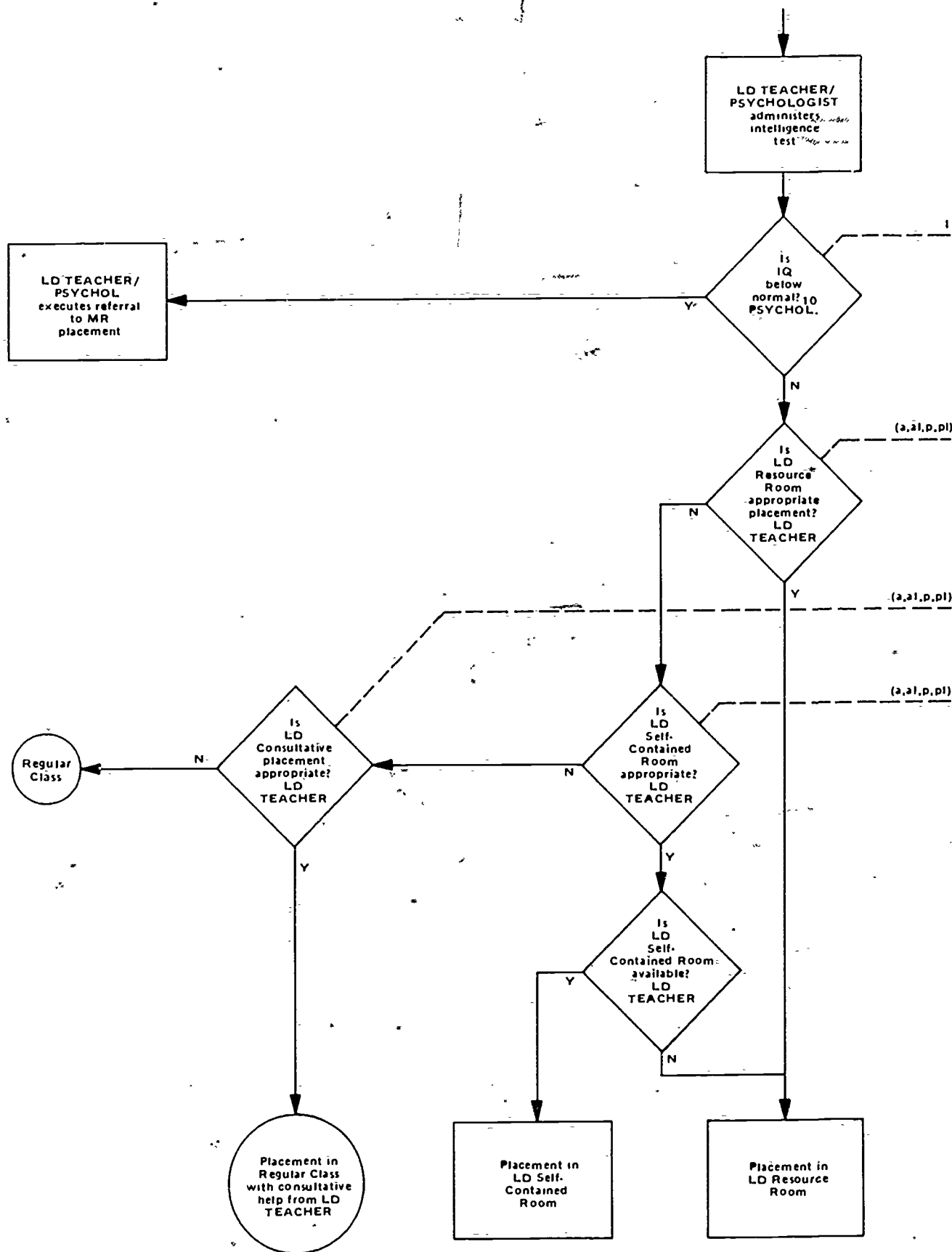
1. Often the problem can be eliminated by changing classrooms or moving the child's seat. This can be determined by the classroom observations.
2. This includes reviewing cumulative records, talking to physicians, and to previous teachers.
3. The LD Consultant is generally the most influential voice on the Diagnostic Team.
4. A neurological examination is required if child is to be classified as Neurologically Impaired LD (severe).
5. Apparently choice of tests is left up to person administering them, although reading, information processing, hearing and vision must be evaluated, choice depends largely on available scores, and attempts are made to fill in gaps in the record.

Project W-5









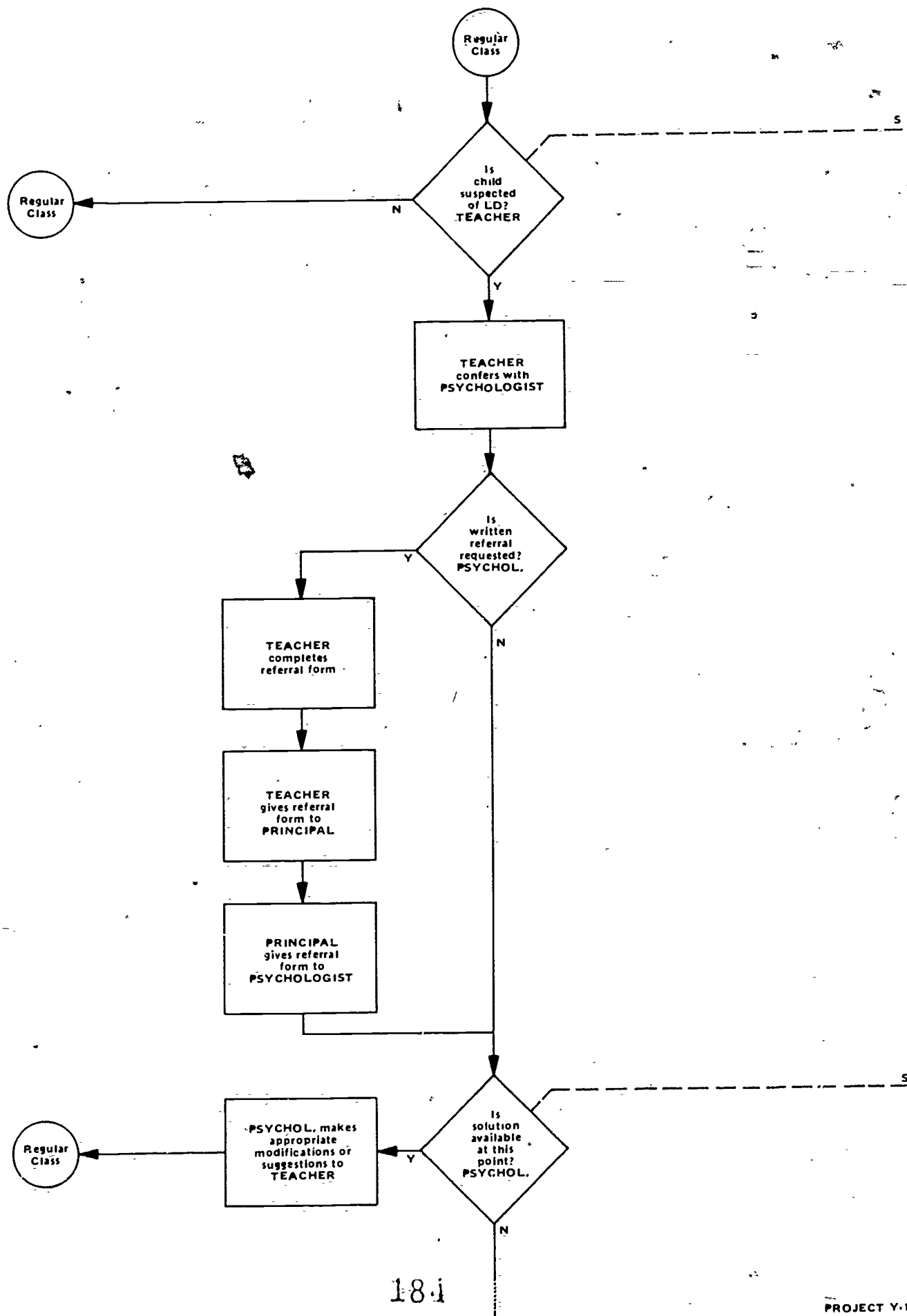
I. GENERAL INFORMATION

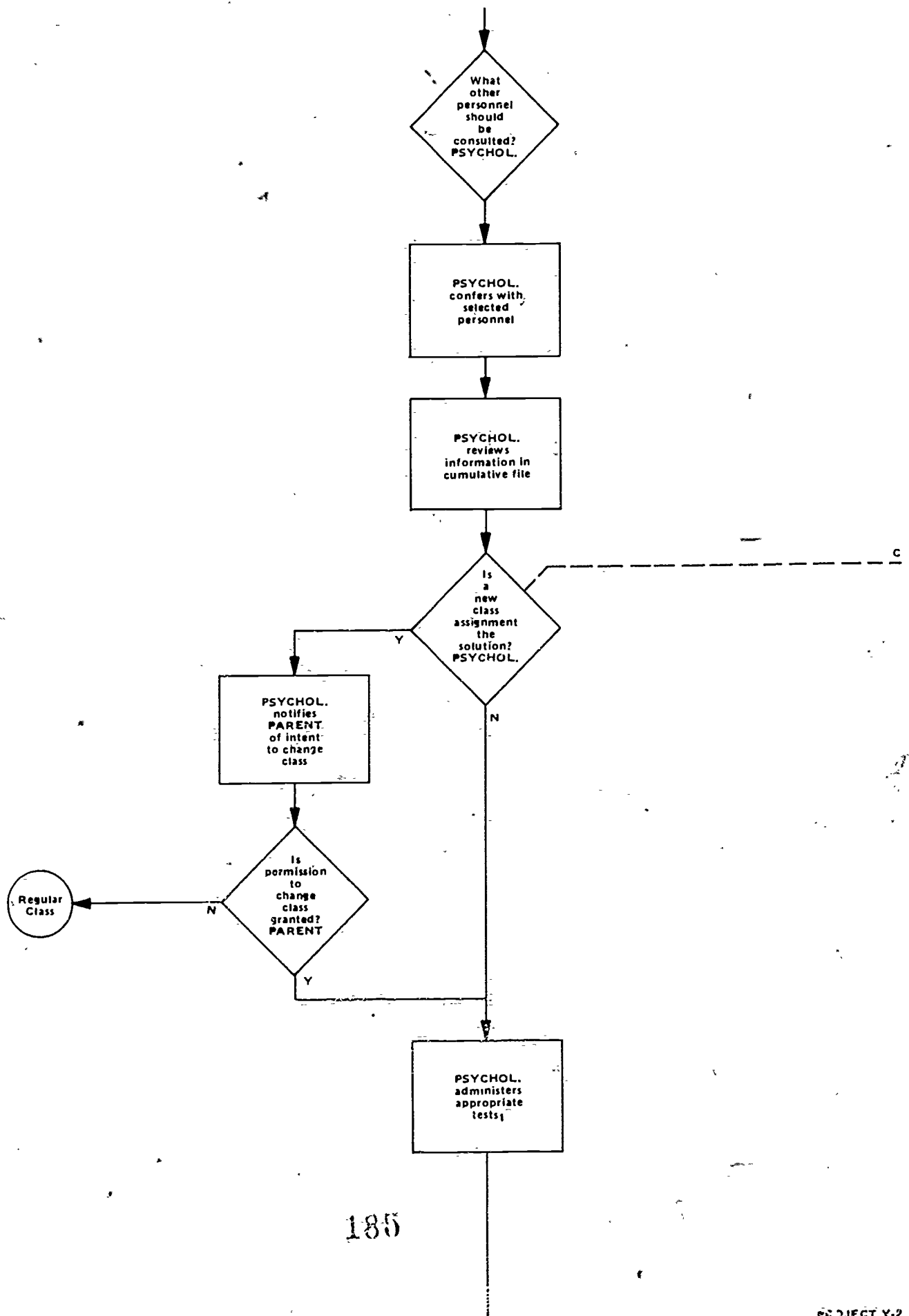
1. Project Code Letter: X
2. Delivery System for Intervention: LD Consultative, LD Resource Room,
LD Self-Contained (Grades 1-6)
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
LD Teacher
Psychologist
 - b) Constraining decisions: LD Teacher

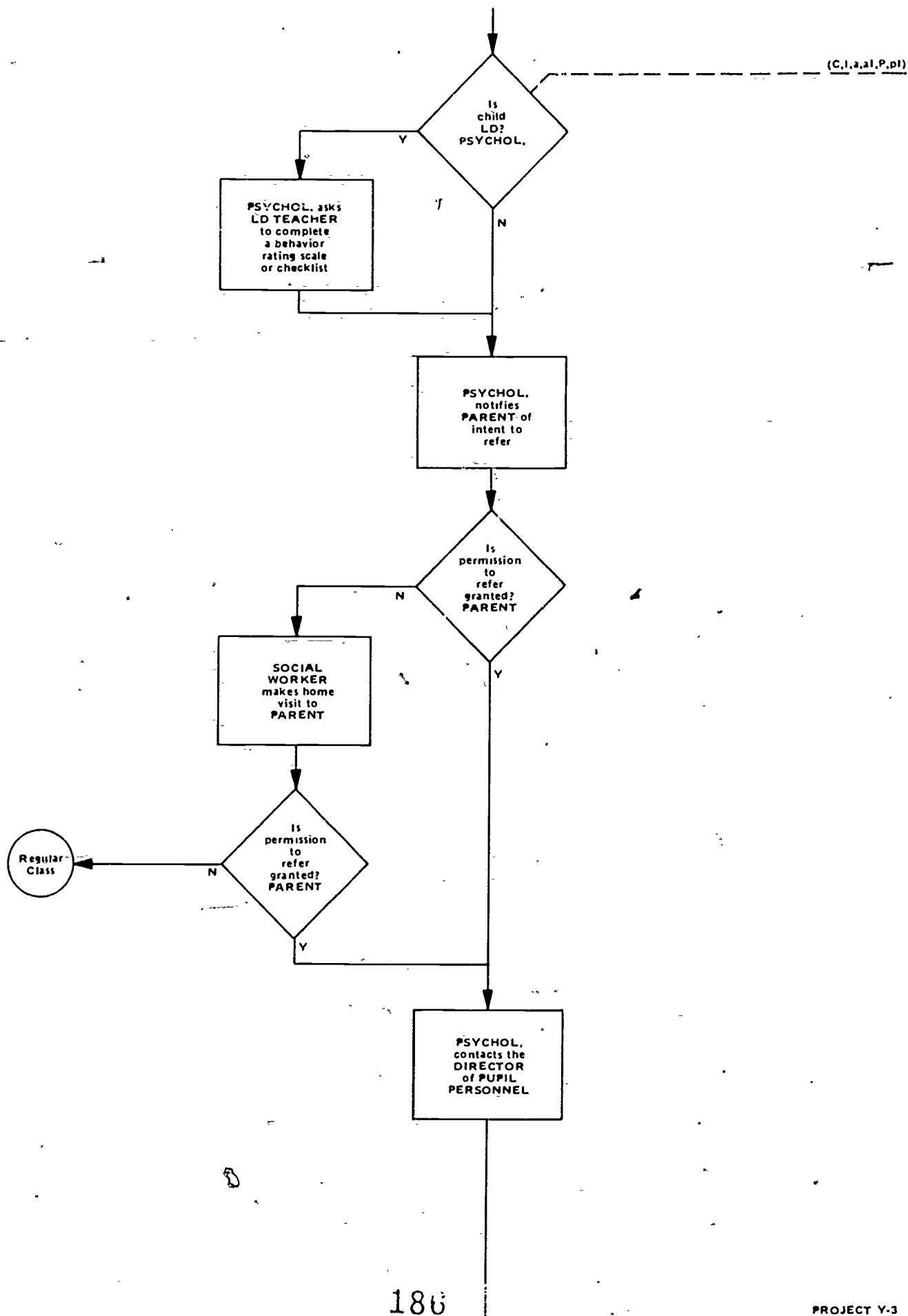
II. SPECIAL NOTATIONS

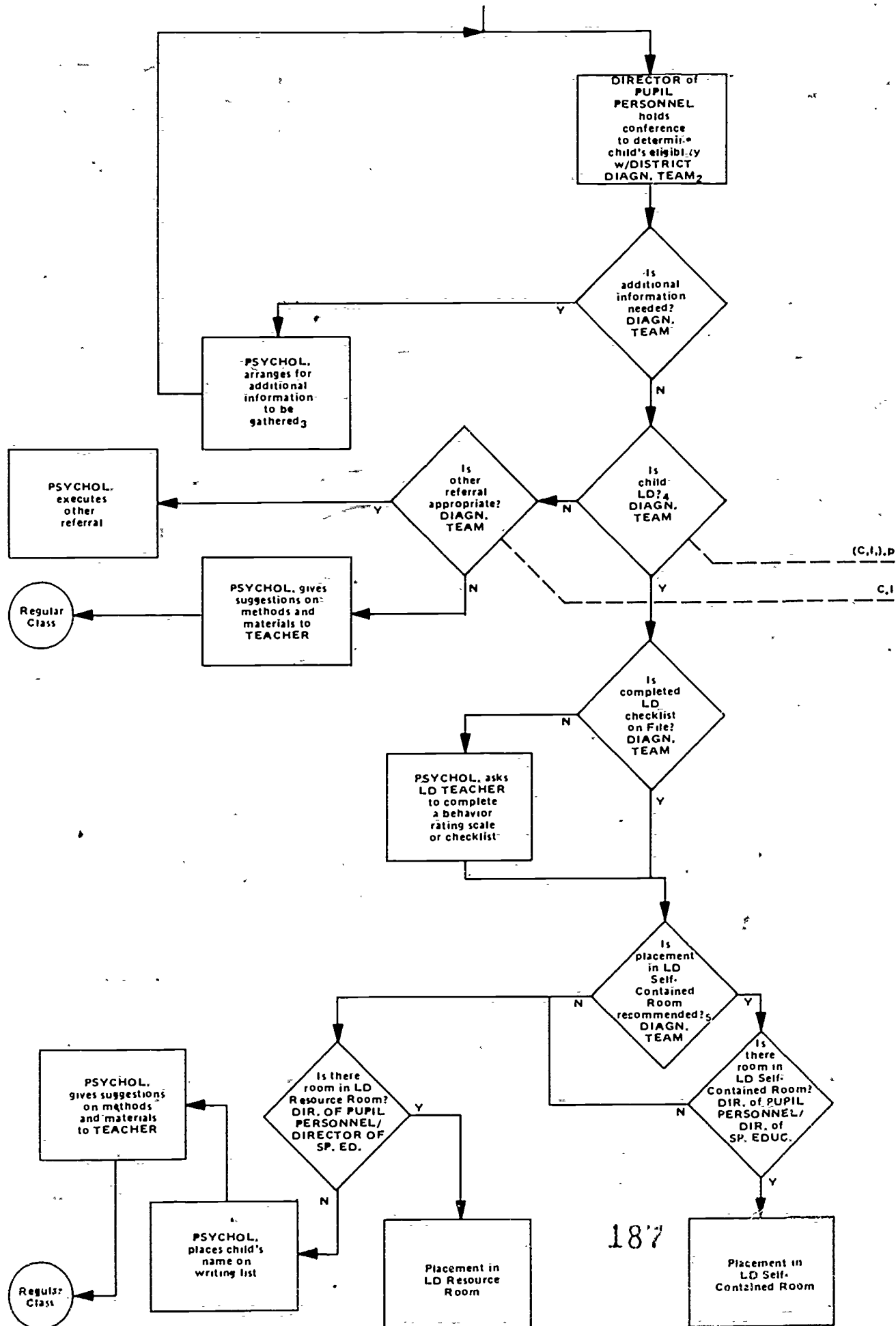
(footnotes apply to notations on flow-chart)

1. Referral form provides record of previous testing, indication of areas of difficulty, some identifying information.
2. Two different pupil behavior rating scales have been used: a) PBRS (Myklebust) and b) locally developed "Classroom Behavior Rating Scale."
3. We will refer to this position as LD Teacher, meaning primarily the LD Resource Room Teacher; this person also serves as an LD Consultant and LD Diagnostician. However, we will refer to this individual according to the central role as LD Teacher.
4. This means, "Will the providing of supportive help (e.g., Behavior Management Techniques) be sufficient to help this child?"
5. Tests include WRAT, BESI, Self-Concept Scale (Sears).
6. Additional tests are determined by the LD Teacher, they would include such things as Durrell, ITAP, Frostig, Spache, etc.
7. This is the critical first stage of intervention with the child; i.e., the first stop is to make suggestions to the Teacher and have her implement them. The essence of this system is that the child is first treated in the class by his regular teacher with no labelling or segregation. If this fails the child can continue into more intensive intervention.
8. This stage again epitomizes the essence of this system: viz, many options and flexibility.
9. Retesting includes Self-Concept, Behavior Rating, BESI, WRAT, plus others at discretion of LD Teacher.
10. State guidelines would be followed, based on available test.









187

I. GENERAL INFORMATION

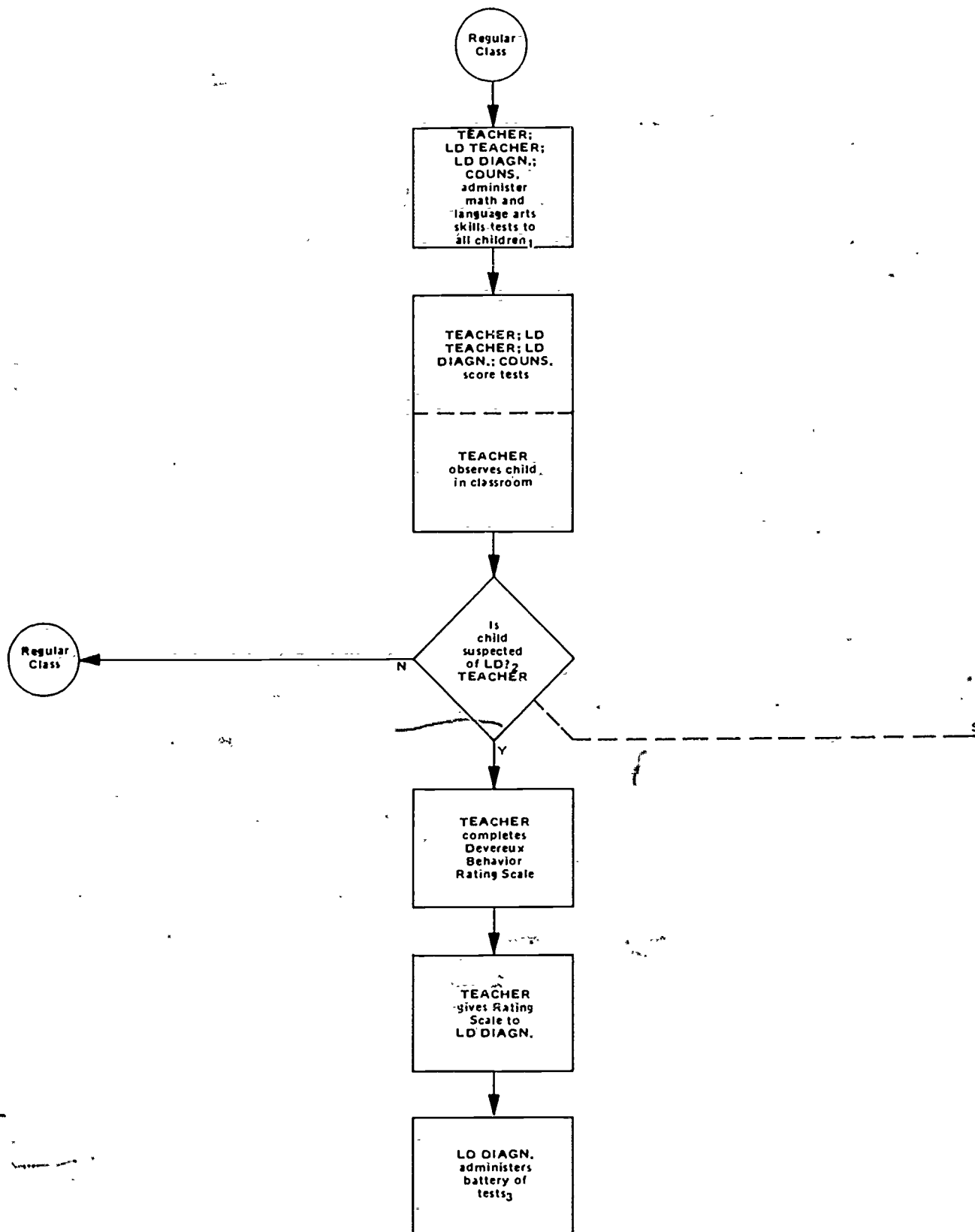
1. Project Code Letter: Y
2. Delivery System for Intervention: LD Self-Contained
LD Specialist Mainstreaming (Grades K-12)
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Psychologist
Diagnostic Team
 - b) Constraining decisions: Psychologist
Parent
Diagnostic Team (Director of Pupil Personnel,
Chief School Psychologist, School Psychiatrist,
Chief Nurse, Social Worker, Director of
Special Education, sending psychologist,
sometimes counselor or referring teacher)
Director of Pupil Personnel/Director of Special
Education

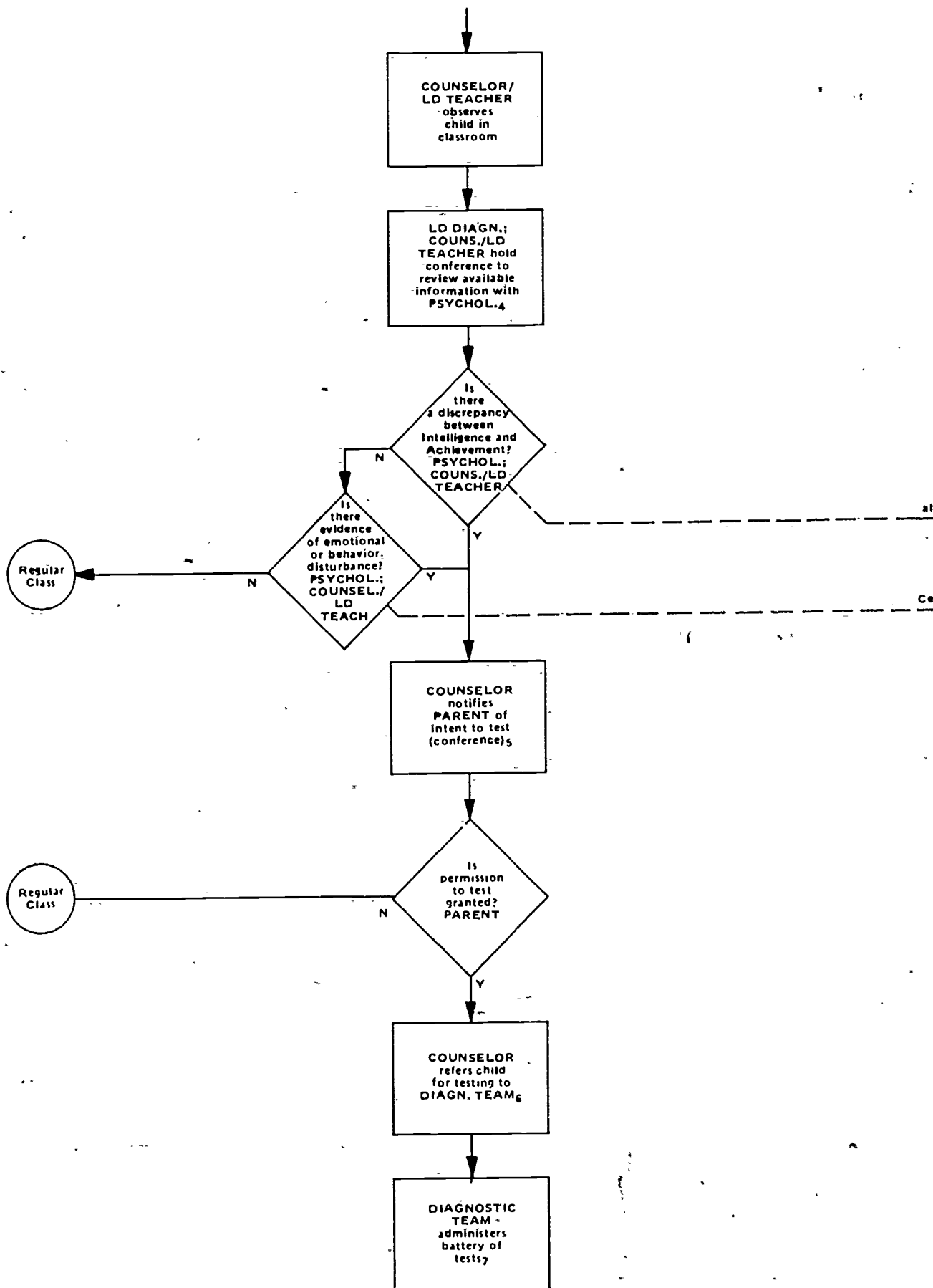
II. SPECIAL NOTATIONS

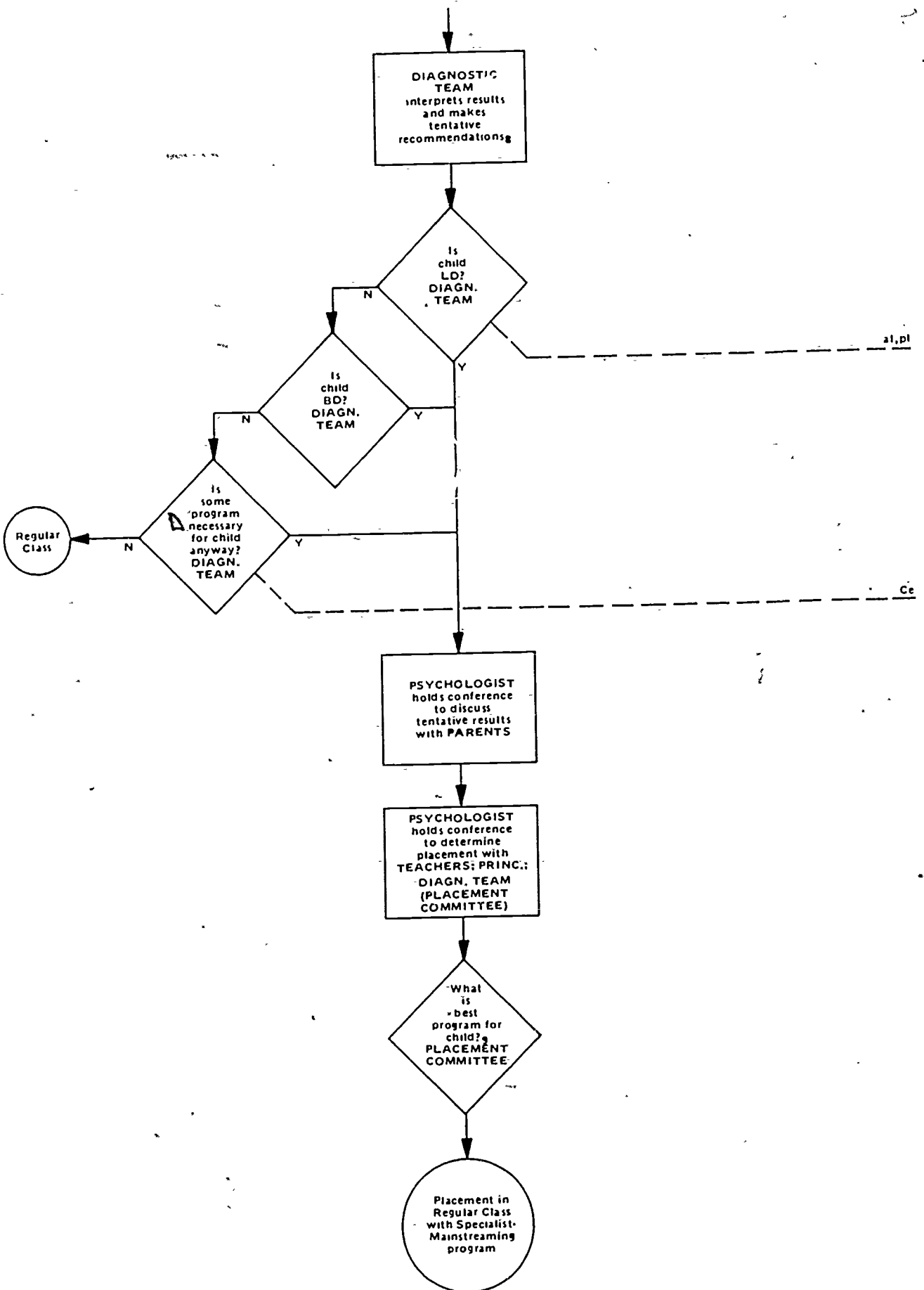
(footnotes apply to notations on flow-chart)

1. Testing includes an IQ test, Bender, maybe Rorschach. If Psychologist suspects LD, may ask remediation specialist to give PBRS or other checklist.
2. This group, headed by the Director of Pupil Personnel includes the School Psychiatrist, Chief School Psychologist, Chief Nurse, Social Worker, Director of Special Education, the sending psychologist, and sometime the counselor or referring agent.
3. This could involve further testing, observation, meeting with parents, etc.
4. The exact criteria by which this decision is made are unclear.
5. The Self-Contained room handles children with emotional as well as LD problems.

Project Y-5







I. GENERAL INFORMATION

1. Project Code Letter: Z
2. Delivery System for Intervention: LD Specialist Mainstreaming (Grades 1-8)
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Psychologist
Counselor/LD Teacher
Diagnostic Team (Psychologist, others)
 - b) Constraining decisions: Parent
Placement Committee (Psychologist, Teachers,
Principals, Diagnostic Team)
Diagnostic Team

II. SPECIAL NOTATIONS

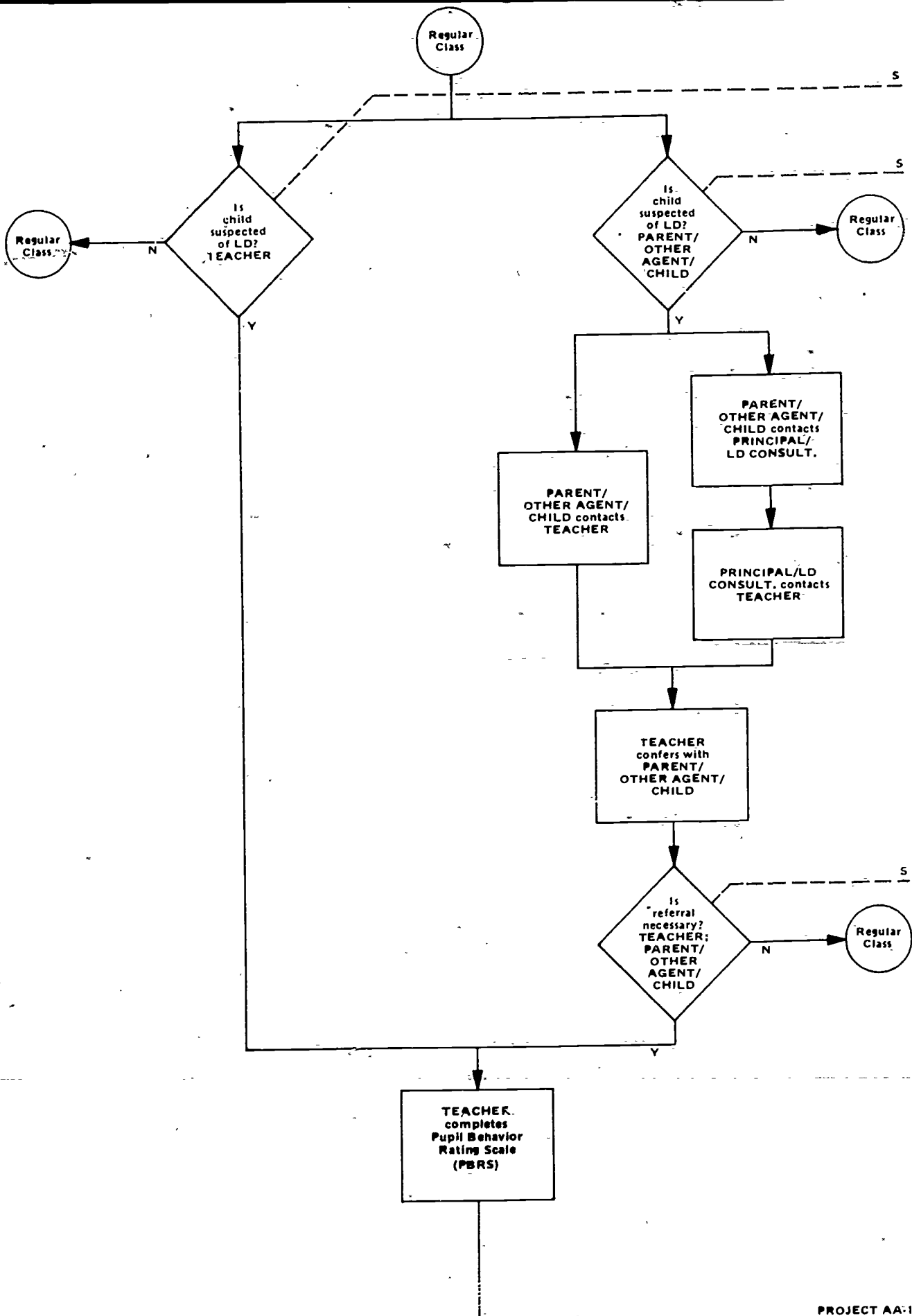
(footnotes apply to notations on flow-chart)

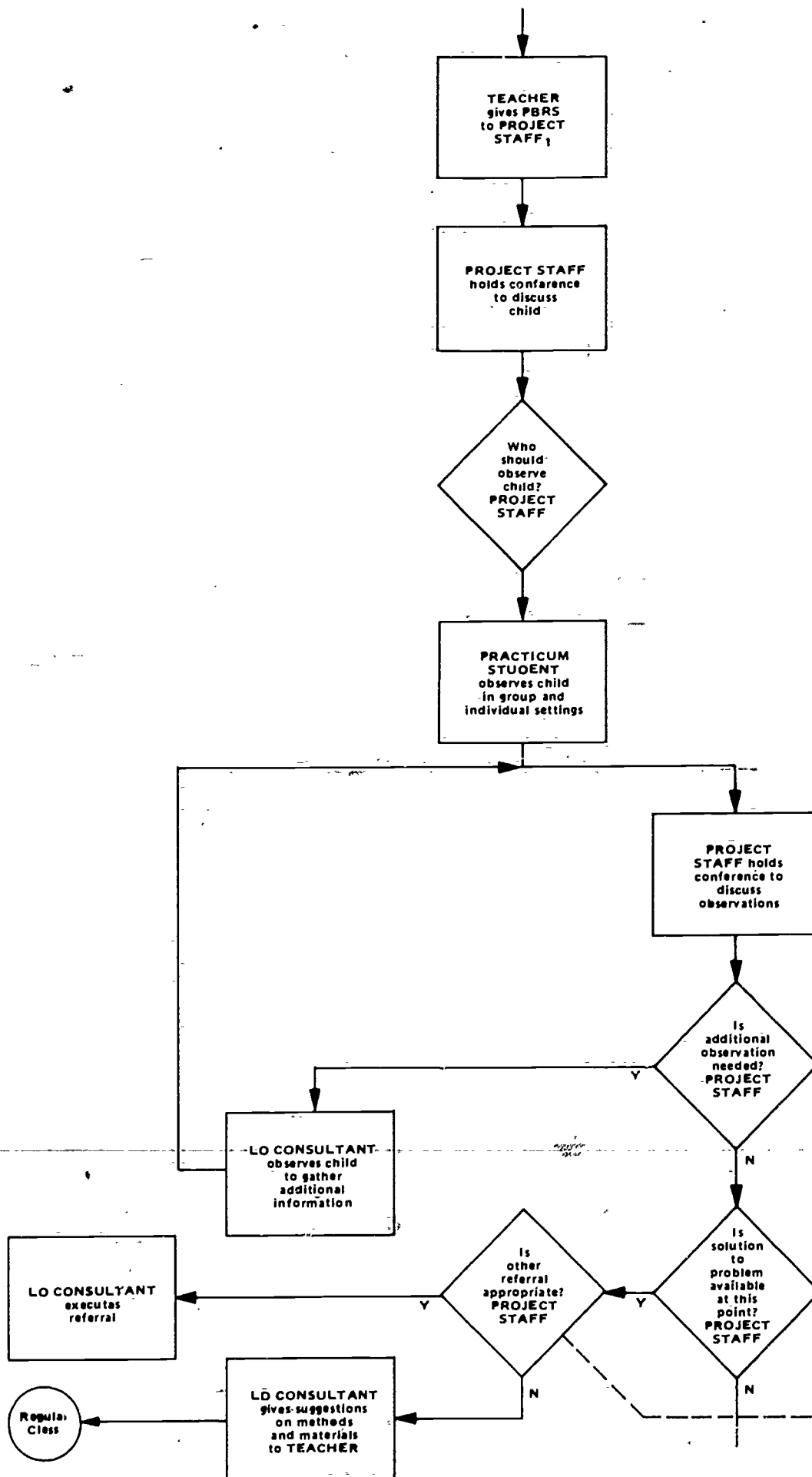
1. These are teacher made tests, administered at the beginning of the school year as a basis for referral.
2. A child is considered a potential LD if he is below the expected level of skill development for his grade level. However, these criteria are flexible with consideration also paid to emotional and background factors of the child.
3. Tests include Slosson, WRAT, Bender-Gestalt, Behavior Rating Scale.
4. Tests are scored prior to the conference, except for the Bender which is scored by the Psychologist and a written summary is prepared from the observations. The conference is held at a tri-county diagnostic center, where the child may go for a more intense work-up, if needed. At this point the child is being viewed as either potential LD or BE (ED). This is why a child may be included if he evidences an emotional disturbance.
5. This conference includes LD Diagnostician, Counselor, Parent and sometime LD Teacher. There is no written permission required, but the parent must orally agree to in-depth testing.
6. This team operates out of the tri-county diagnostic center. "Diagnostic Team" will be used to refer the staff at this center. Except for a Psychologist, team members are not known.
7. Tests include WISC, or Binet, ITPA, achievement tests, a parent rating scale, family history and child history.
8. Criteria used to eliminate a child at this point are unknown. However, it is assumed that all tested children will receive some remedial help, whether

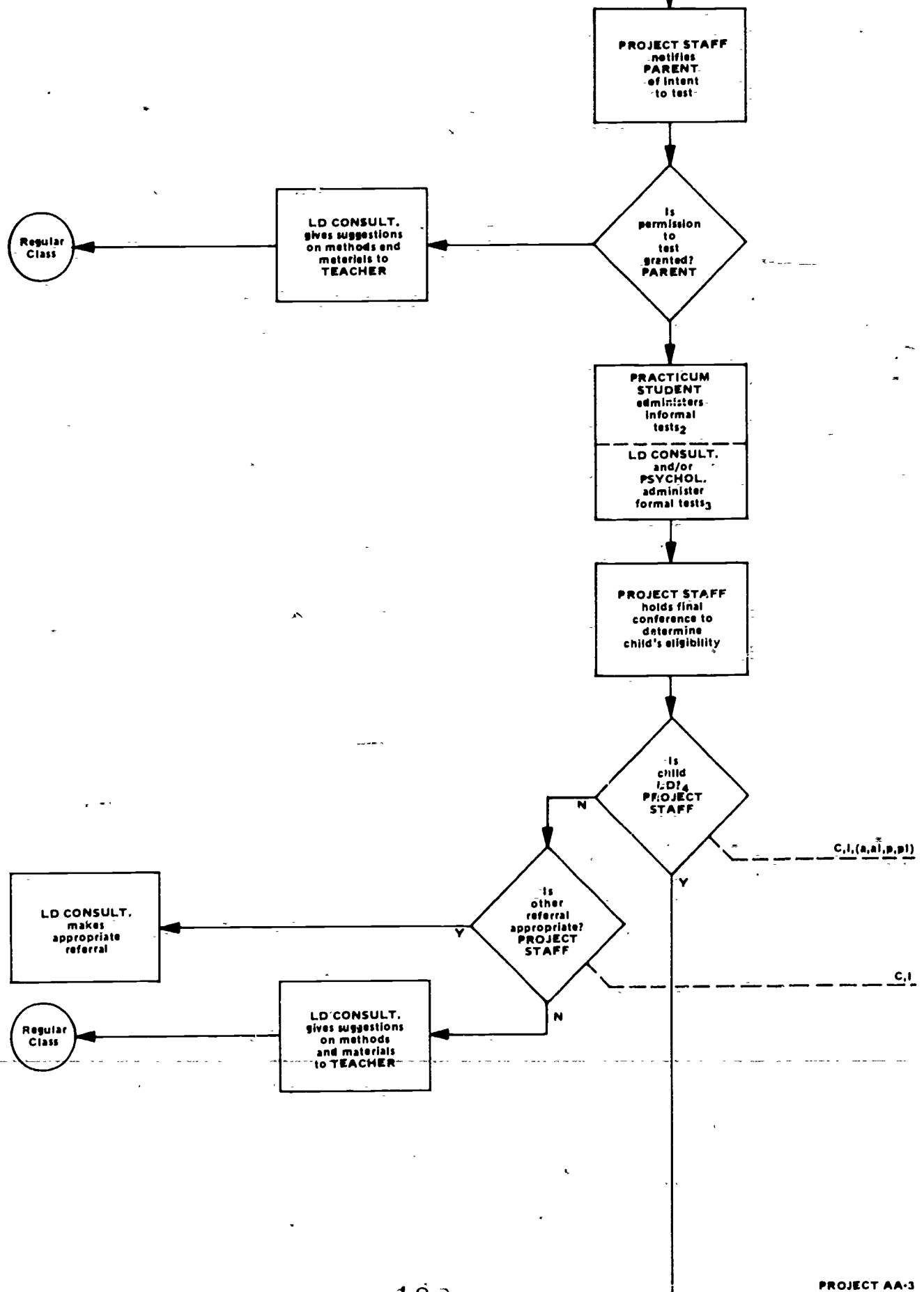
designated as LD or not. This is largely because the project's philosophy centers around adjusting a school program to each child's needs and learning patterns.

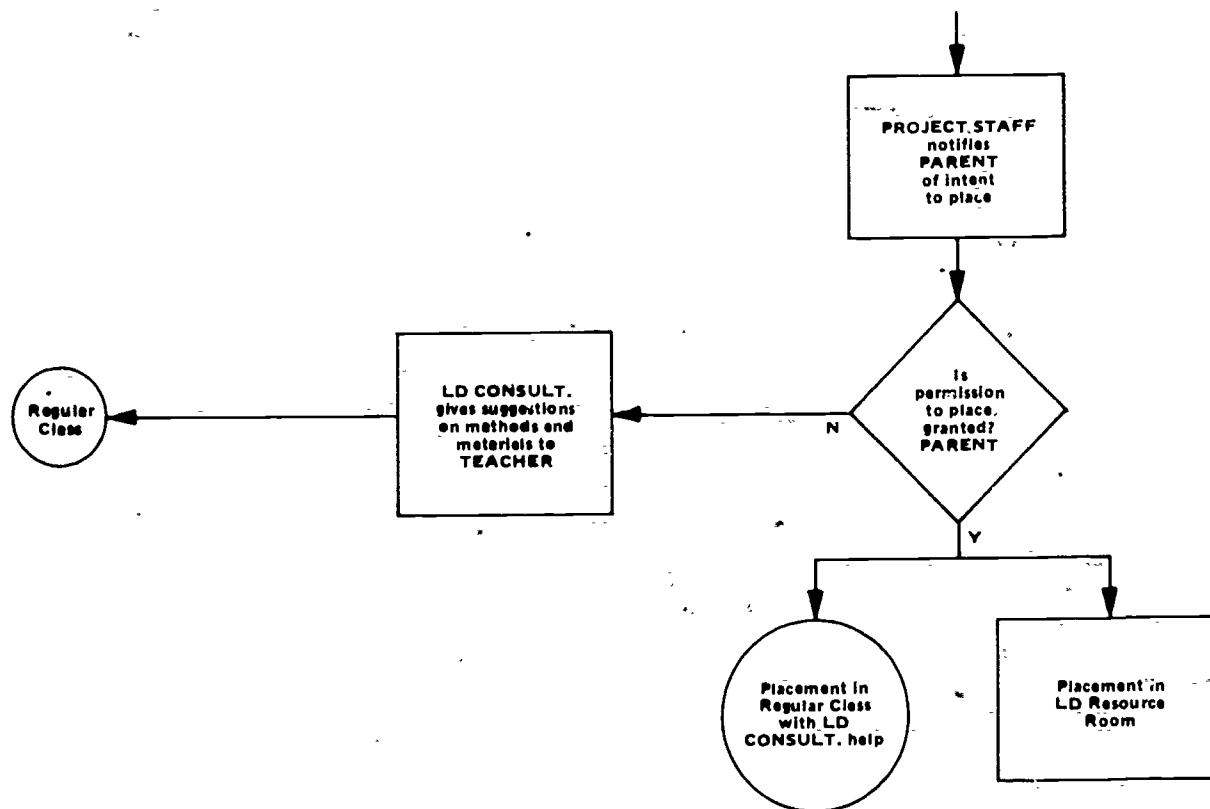
9. Possibilities include individual tutoring, programmed learning, family counseling, bookless curriculum, family groupings in class, role playing.

Project Z-5









I. GENERAL INFORMATION

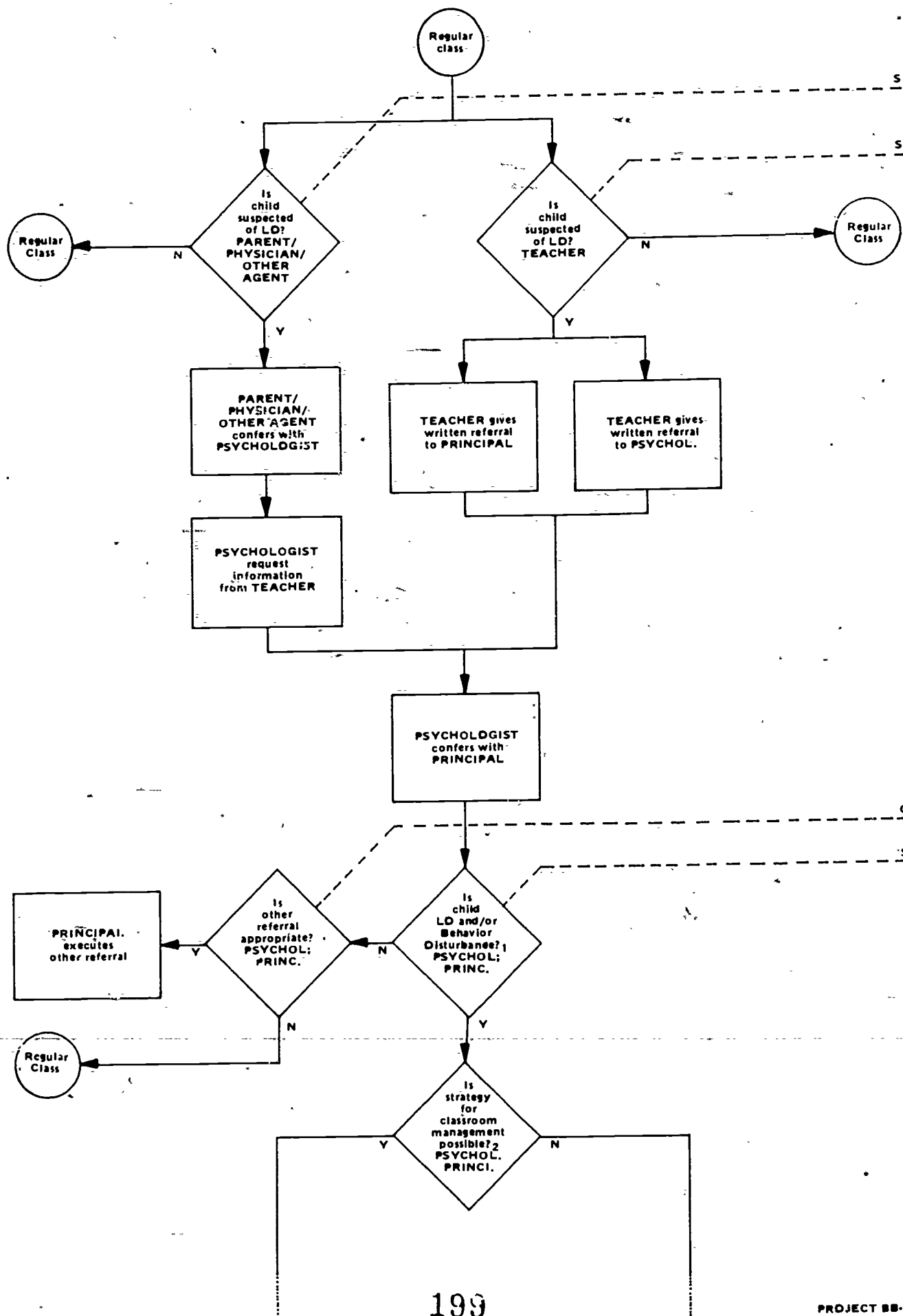
1. Project Code Letter: AA
2. Delivery System for Intervention: LD Consultative (Grades K-12)
LD Resource Room
3. Initial Entry: Referral (Teacher, Parents/other Agents/Self)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Parent
Other Agent
Child
Project Staff (LD Coordinator, Psychologist,
LD Consultants, Practicum Students)
 - b) Constraining decisions. Project Staff
Parent

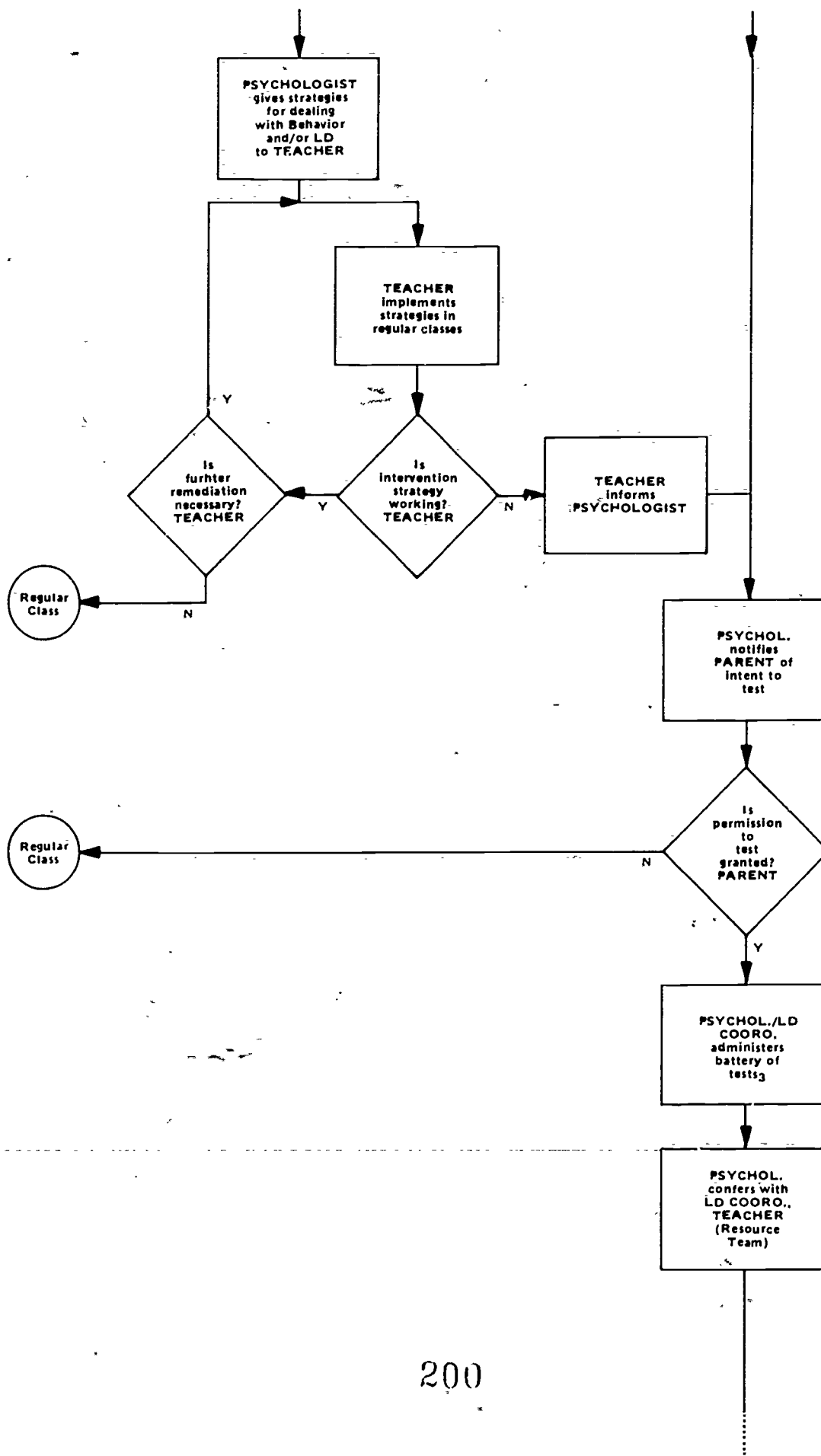
II. SPECIAL NOTATIONS

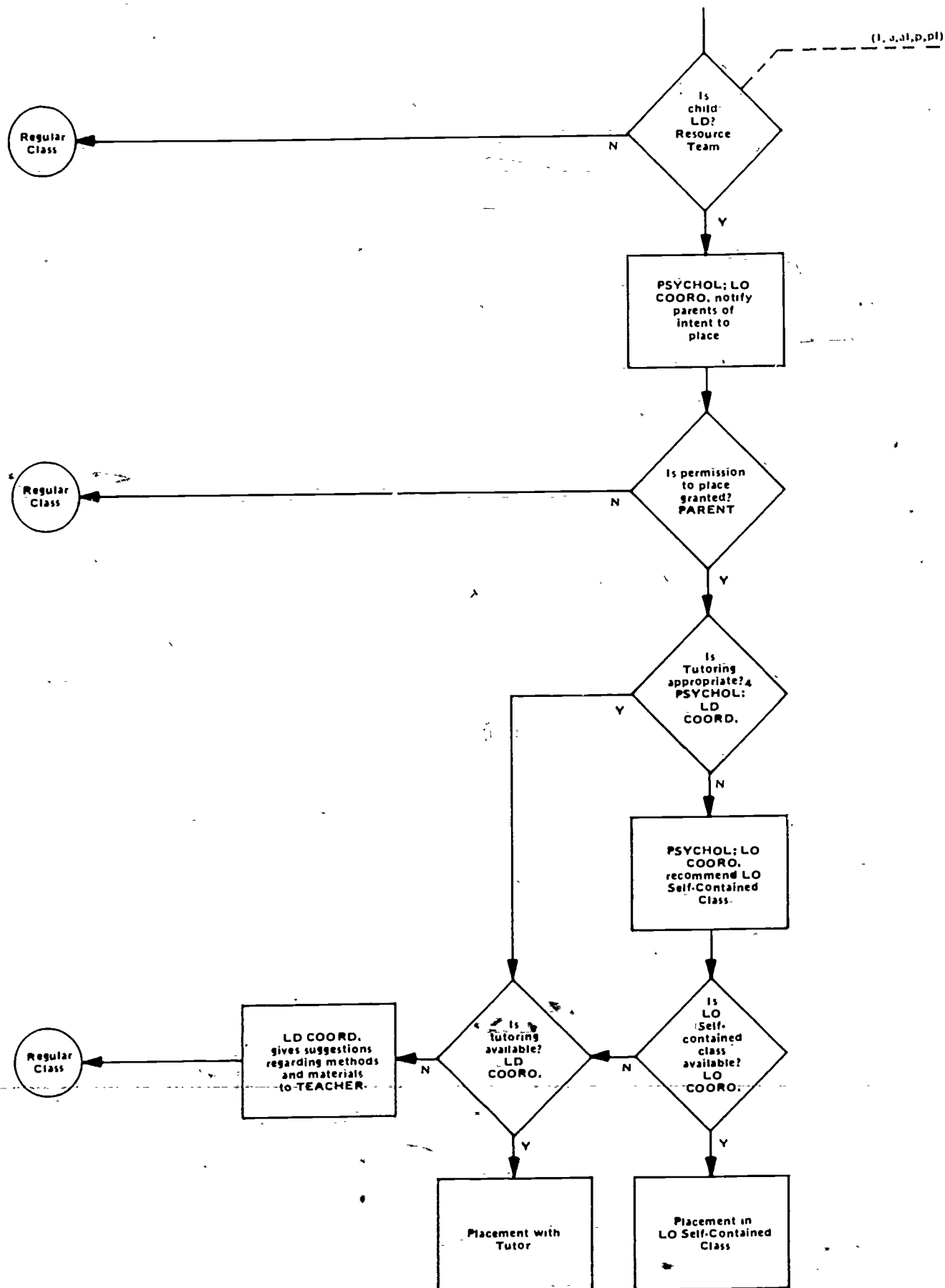
(footnotes apply to notations on flow-chart)

1. Staff includes 5 LD Consultants who serve as itinerant personnel, an LD Coordinator, a Psychologist, and 10 practicum students. The referral would probably go to one of the 5 consultants or a practicum student, since personnel are most frequently in a school. The term "Project Staff" will be used when the specific member of the staff is not known.
2. Informal tests include Wold Screening Tests, Silvaroli, Key-Math, WRAT, in addition, samples of child's work may be collected.
3. Formal tests include WISC or Binet, ITPA, Bender, Draw-A-Person, etc. LD Consultants do most of the testing; the Psychologist would be called in if emotional problems appeared to be primary.
4. Specific criteria are not known. It appears that the project does use a broad definition of LD, including nearly any kind of disability for which they can provide some remedial services.

Project AA-5







I. GENERAL INFORMATION

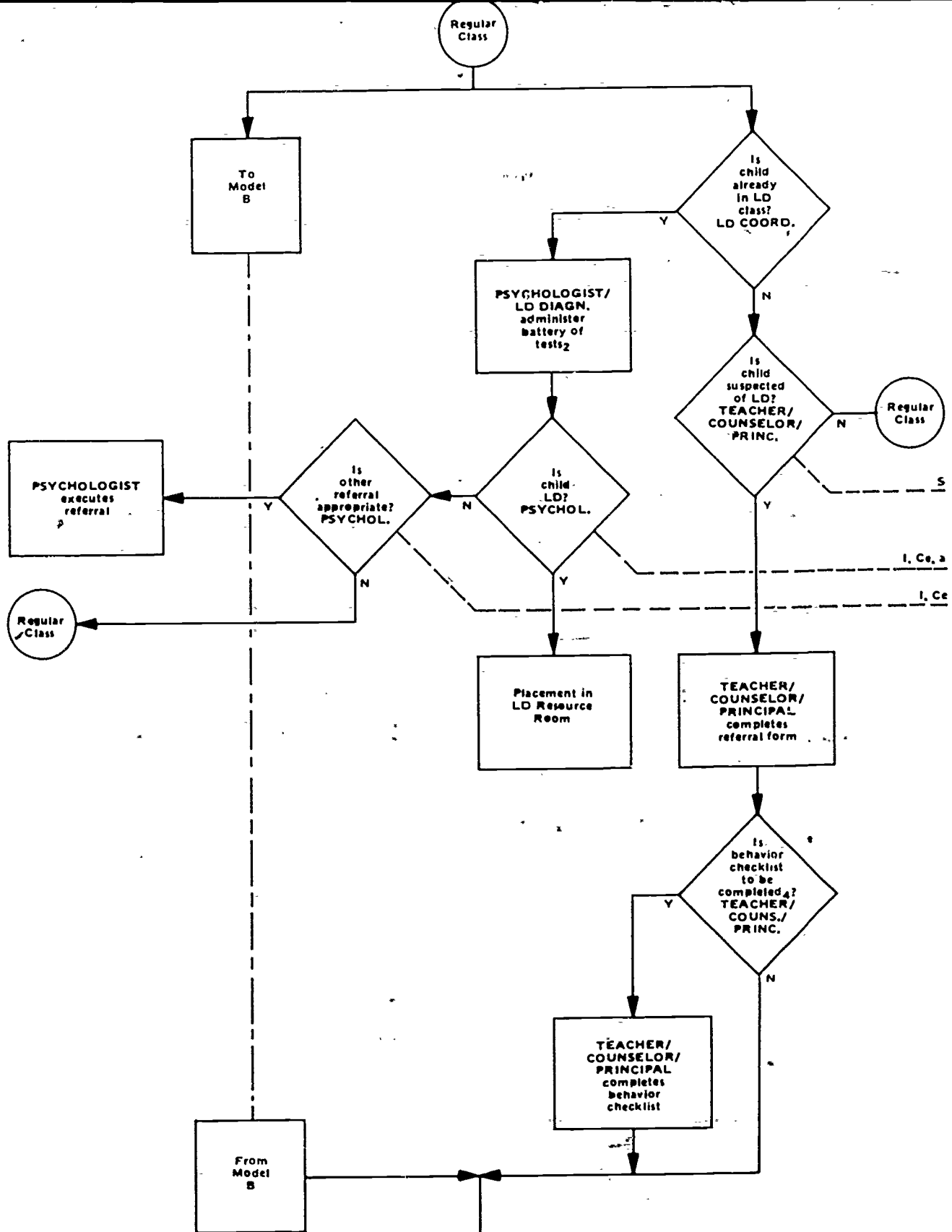
1. Project Code Letter: BB
2. Delivery System for Intervention: LD Self-Contained (Grades 9-12)
LD Specialist
Mainstreaming
3. Initial Entry: Referral (Teacher/Parent/Physician/Other Agent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher - Psychologist
Parent Principal
Physician Resource Team (LD Coordinator,
Other Agent Psychologist, Teacher)
 - b) Constraining decisions: Psychologist
Principal
Teacher
Parent
LD Coordinator

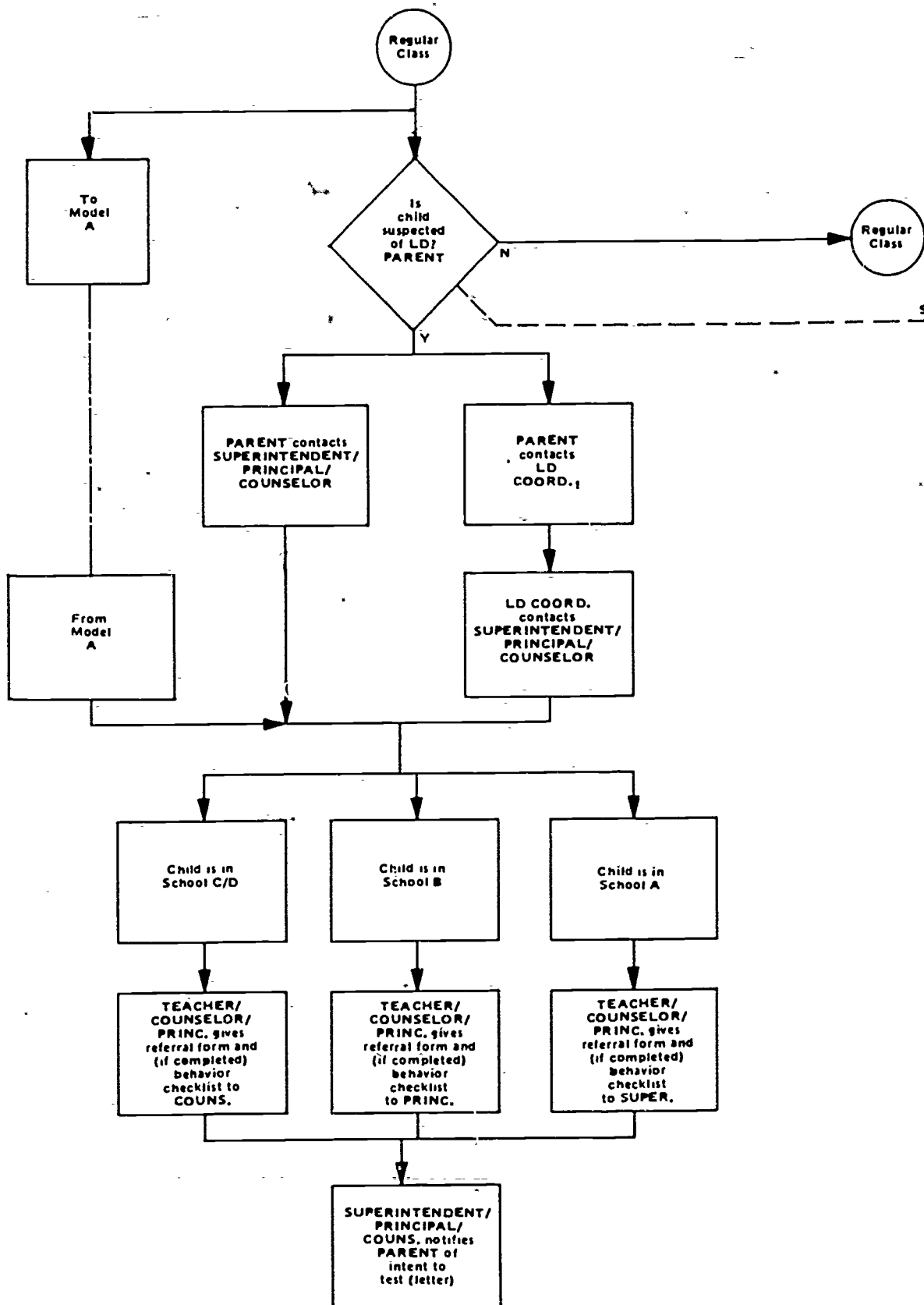
II. SPECIAL NOTATIONS

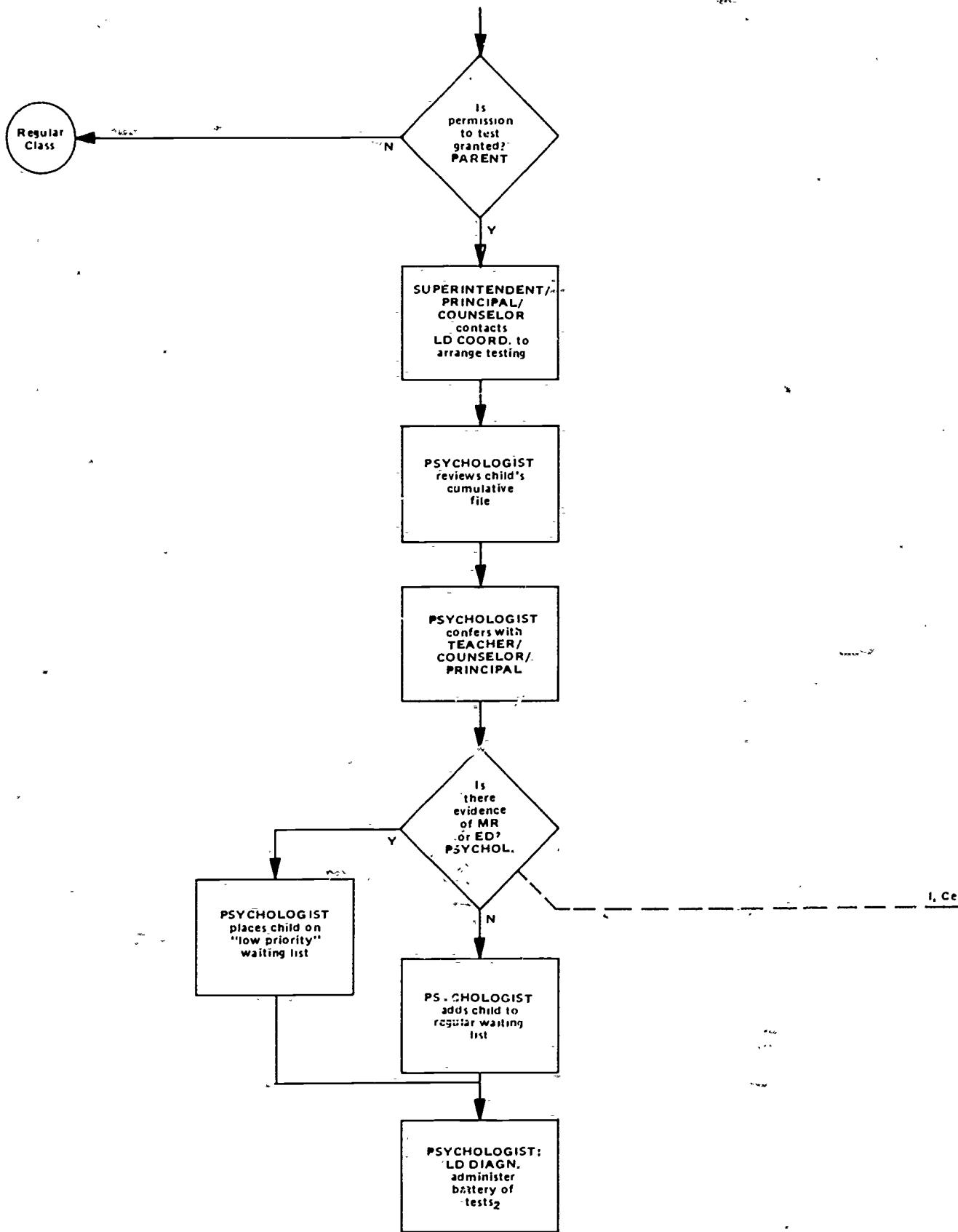
(footnotes apply to notations on flow-chart)

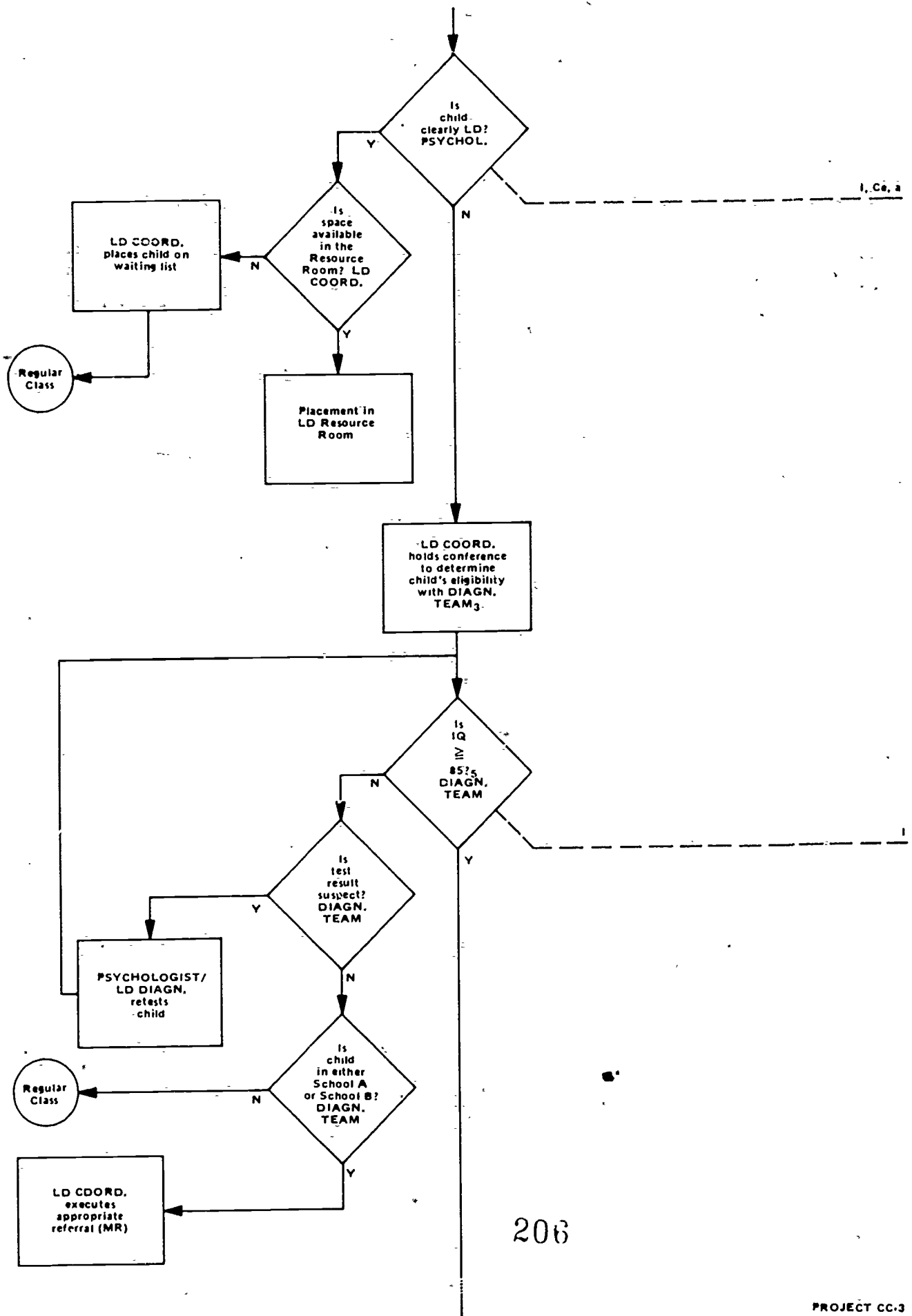
1. In this system LD and BD (Behavior Disturbance) children are often grouped together.
2. The essence of this system is to attempt to work with the child as quickly as possible with a minimum of testing. Other specialists may be called in to give itinerant service; e.g., Speech Therapist, Language Therapist, Visiting Teacher.
3. Exact tests not available or constant; determined by LD Coordinator (Diagnostician) and Psychologist.
4. Tutoring means an itinerant LD Teacher.

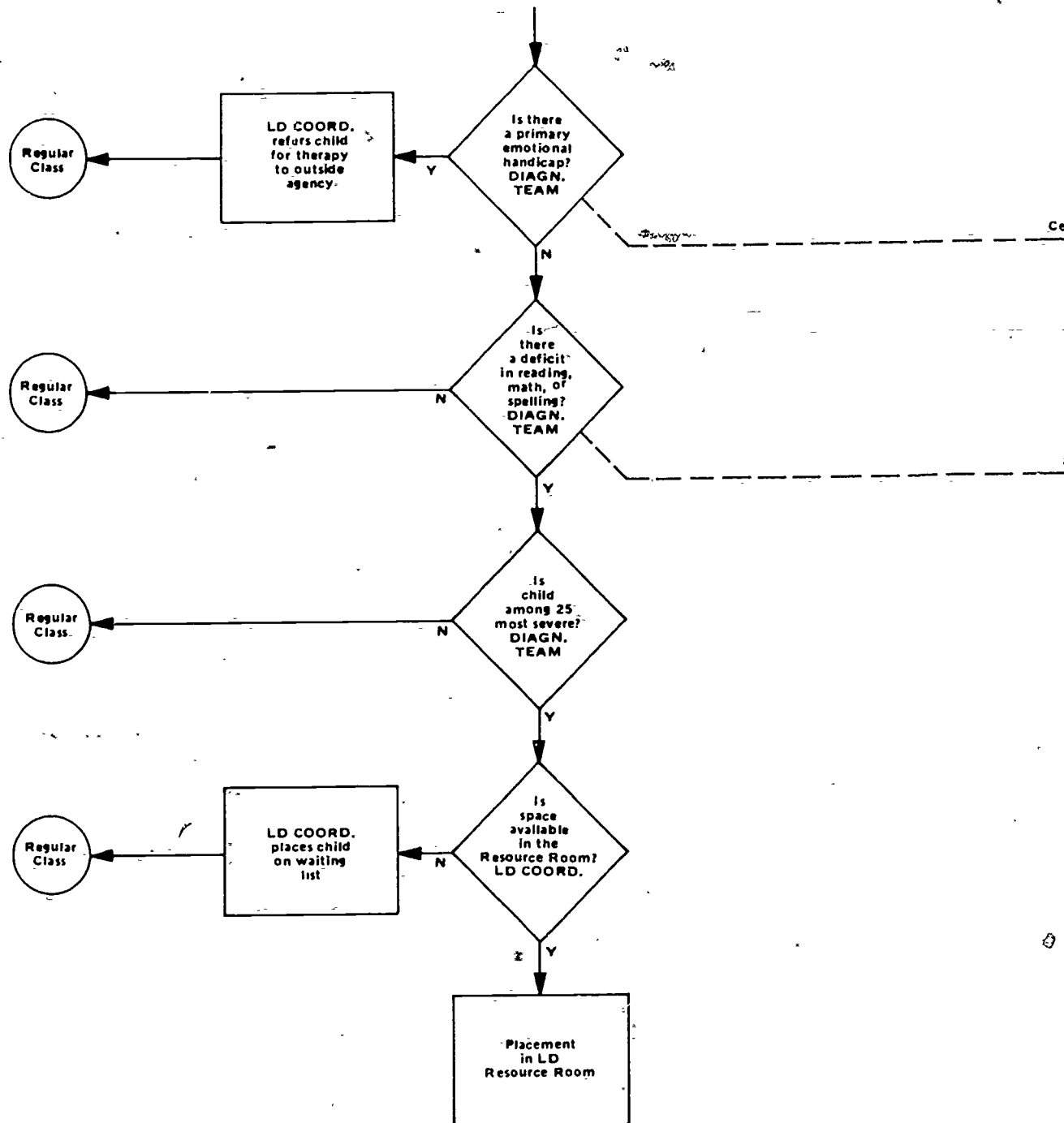
Project BB-4











I. GENERAL INFORMATION

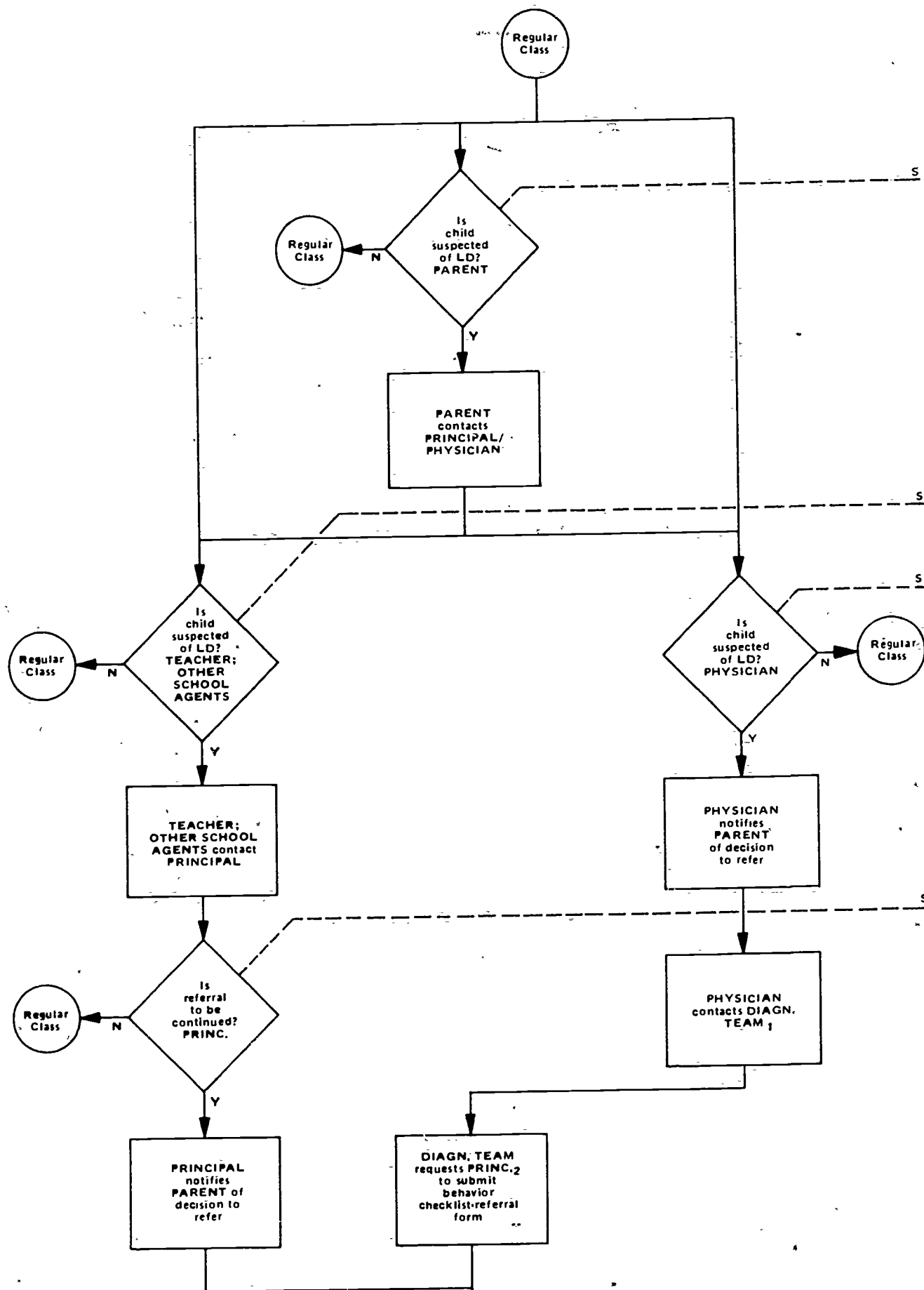
1. Project Code Letter: CC
2. Delivery System for Intervention: LD Resource Room (Grades 7-12)
3. Initial Entry: Referral (Teacher/Counselor/Principal/Parent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent Diagnostic Team (LD Coordinator,
Psychologist 2 LD Diagnosticians,
Teacher Psychologist)
Counselor
Principal
 - b) Constraining decisions: LD Coordinator
Teacher
Counselor
Principal
Parent
Diagnostic Team (LD Coordinator, 2 LD Diagnosticians,
Psychologist)

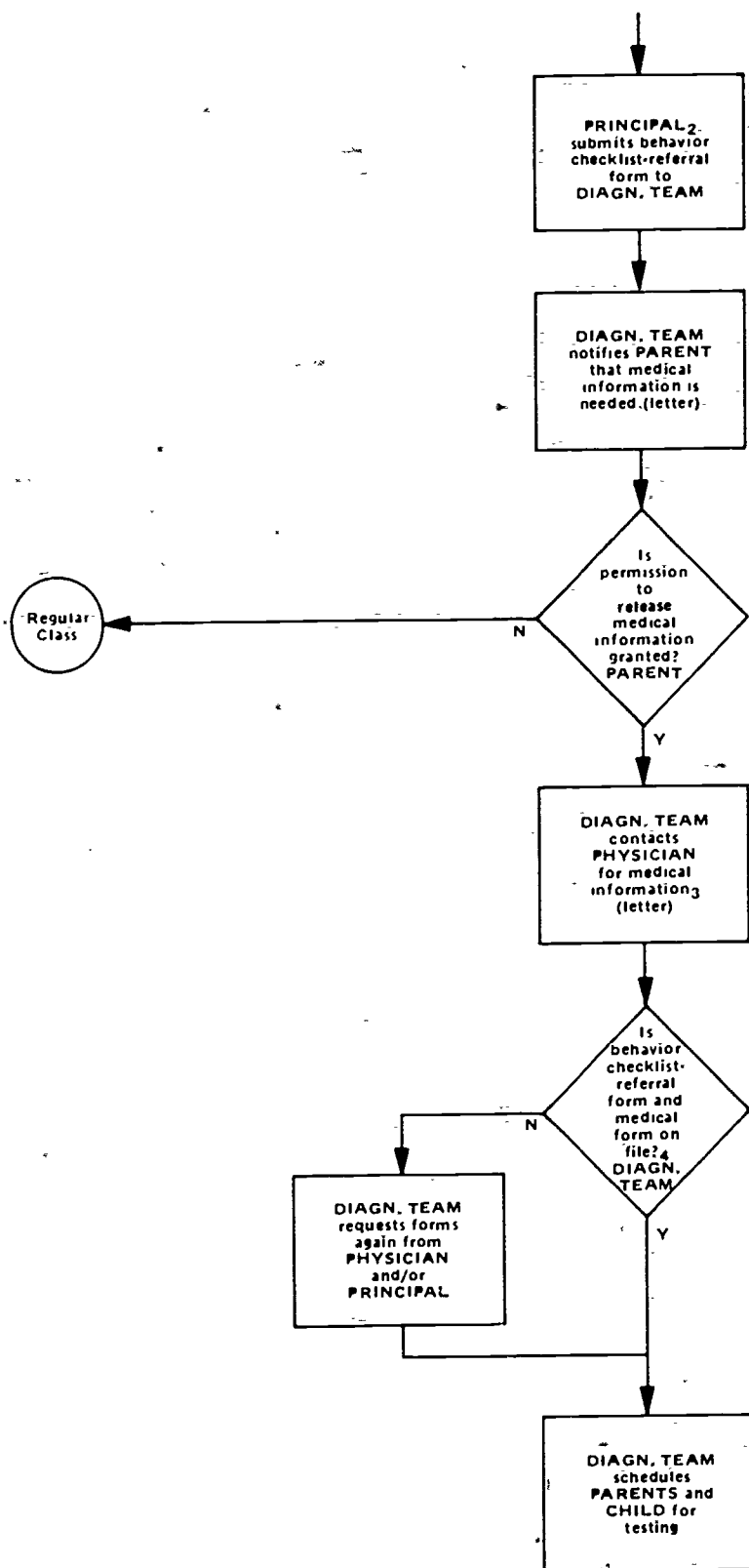
II. SPECIAL NOTATIONS

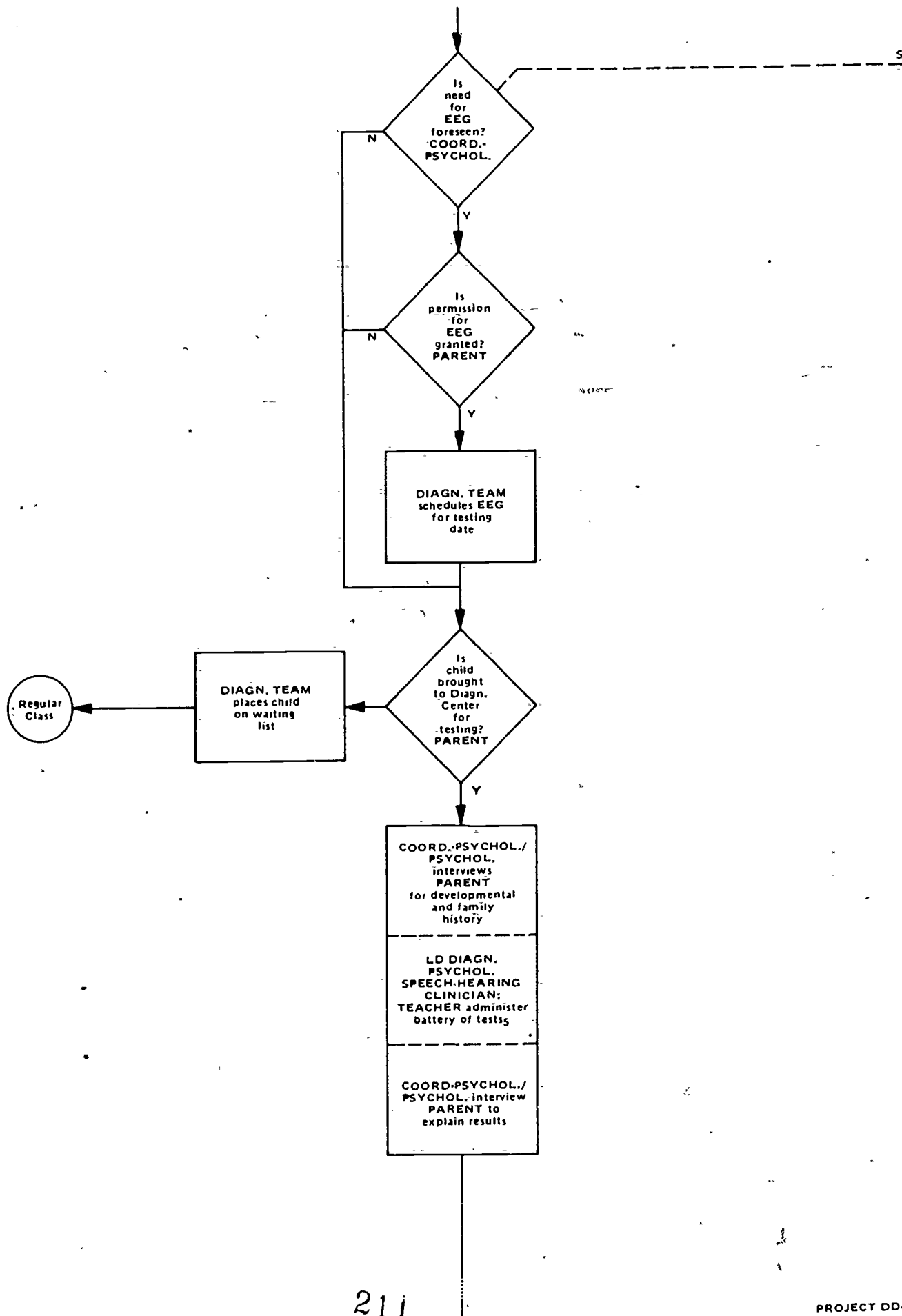
(footnotes apply to notations on flow-chart)

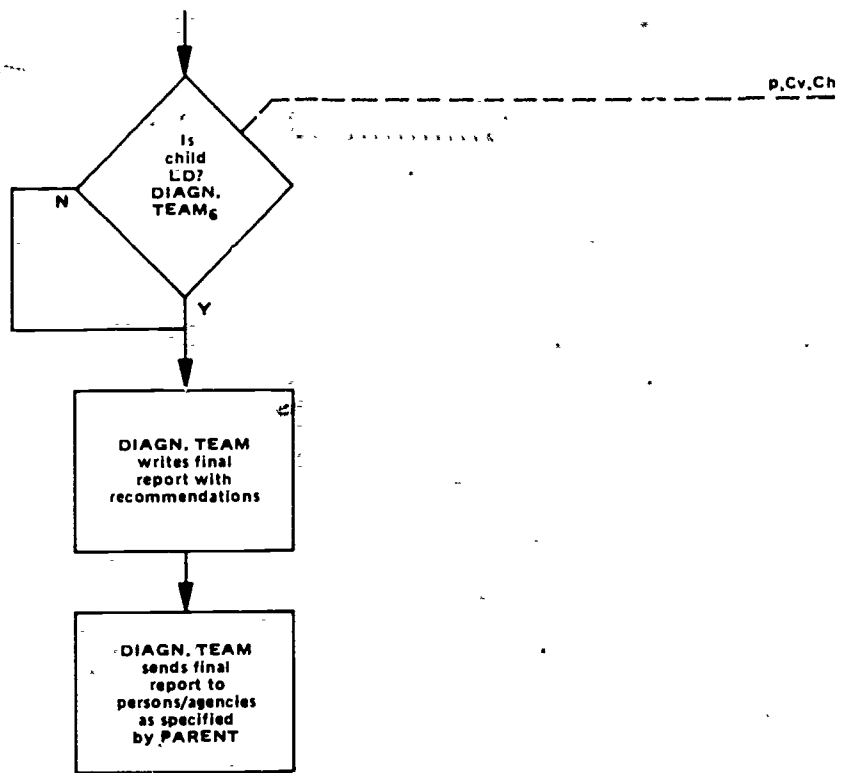
1. LD Coordinator is Title VI-G local project director.
2. Tests include WISC, WRAT, Durrell, Stanford Arithmetic and Reading, Projective Test (selected by Psychologist), Bender, Draw-A-Man, House-Tree-Person Test.
3. Diagnostic Team includes LD Coordinator, 2 LD Diagnosticians, and a Psychologist.
4. About 20% of referrals include checklist.
5. IQ is based on Full Scale.

Project CC-5









I. GENERAL INFORMATION

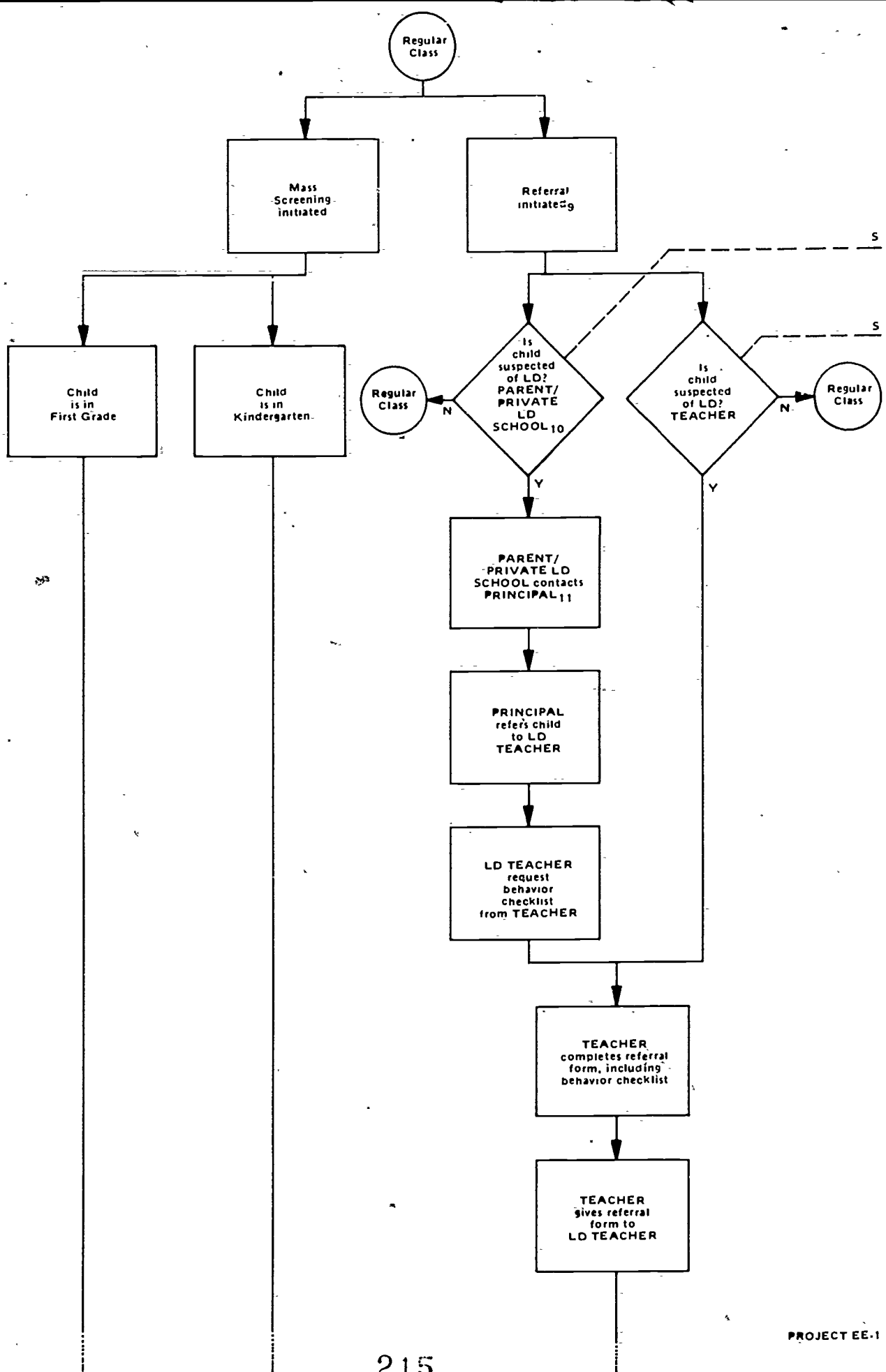
1. Project Code Letter: DD
2. Delivery System for Intervention: LD Consultative (Ages 3-12)
3. Initial Entry: Referral (School/Physician)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Parent
Physician
Teacher
Other School Agents
Principal
Coordinator-Psychologist
Diagnostic Team (LD Diagnostician, Psychologists, Coordinator, Speech & Hearing Clinician, Instructional Materials Specialist, Teacher)
 - b) Constraining decisions: Parent
Diagnostic Team
(LD Diagnostician, Psychologists, Coordinator, Speech & Hearing Clinician, Instructional Material Specialist, Teacher)

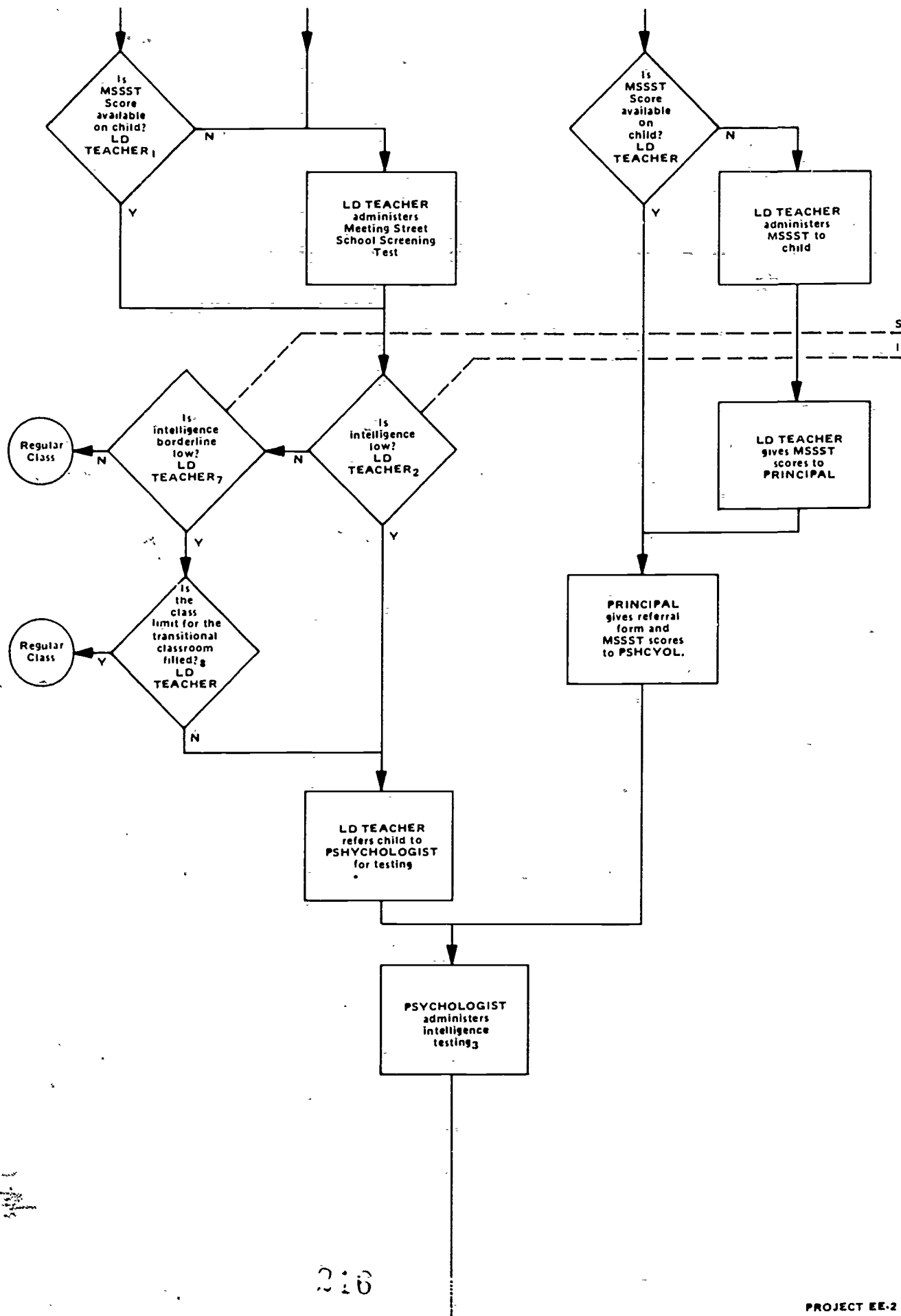
II. SPECIAL NOTATIONS

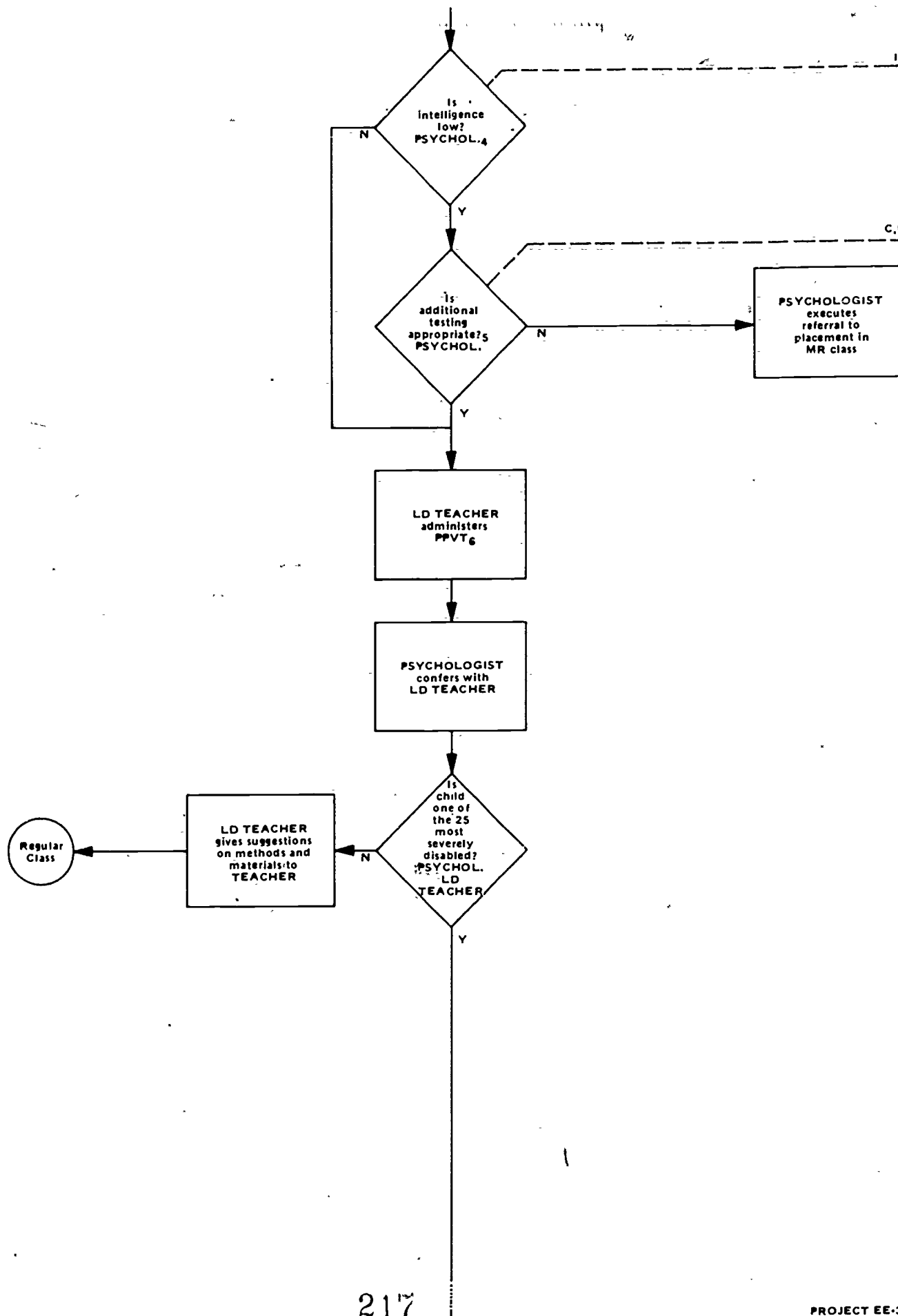
(footnotes apply to notations on flow-chart)

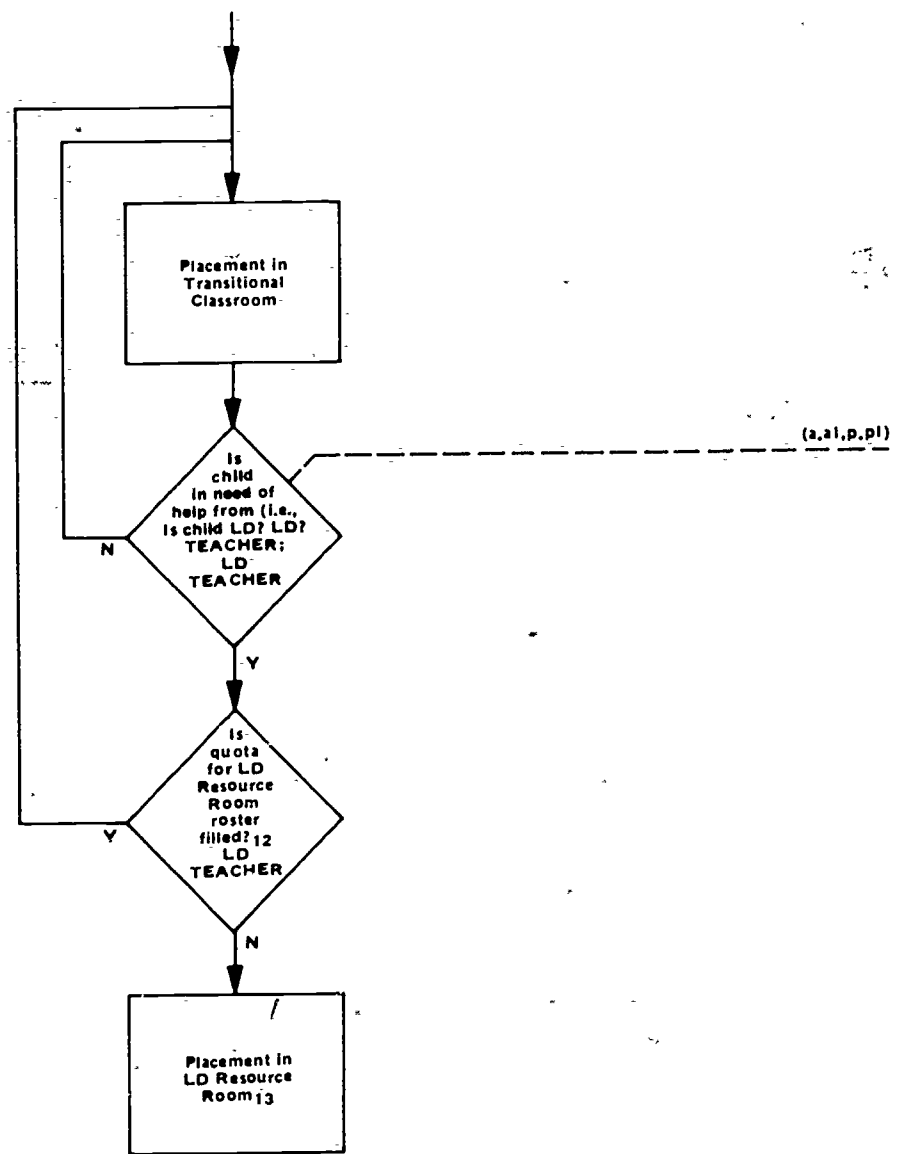
1. No one person is specified. It is assumed that referrals are all processed thru a standard procedure which does not require that any one person in particular be contacted, since all Team members operate out of a Diagnostic Center. The Center staff consists of 2 LD Diagnosticians, 3 Psychologists (one of whom serves as coordinator), 1 Speech-Hearing Clinician, 1 Instructional Materials Specialist, 1 Teacher.
2. Although the Principal is not necessarily the one who completes the form (he may request any staff member(s) to do this), he is responsible for submitting it to the Diagnostic Center.
3. The Physician is asked to complete a checklist and descriptive form relating to child's behavior and suspected causes, developmental history, relevant family history current medications, similar problems in siblings.
4. In many cases the available medical information is missing entirely or extremely inadequate.
5. Specific tests used are not know, but evaluation is made in the following areas: intelligence, behavior, vision, hearing, speech, language, academic.
6. The Coordinator-Psychologist appears to be most influential in this decision. It is difficult to determine very exact criteria, however, deficits in some psychological processes are considered relevant. It also appears likely, since vision and hearing screening are done, that these are considered as

elimination factors. Intelligence is not applied as a relevant criteria, while conditions of environment are believed to be highly relevant causes of LD. It should be noted that the Diagnostic Center is concerned with evaluating and recommending solutions for all children referred, as such, the emphasis is not really on identifying LD children.









I. GENERAL INFORMATION

1. Project Code Letter: EE
2. Delivery System for Intervention: LD Resource Room (Combined with Transitional Classes) (Grades 1-2)
3. Initial Entry: Referral (Teacher/Parent/LD Private School)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: LD Teacher
Teacher
Psychologist
Parent
Private LD School
 - b) Constraining decisions: LD Teacher
Psychologist

II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

1. This means, "Was the Meeting Street School Screening Test given to the child in Kindergarten?"
2. The question is a broad one, based on results of the MSSST, the criterion here is: "Is the child in the lowest quartile on the MSSST?"
3. Testing includes WISC or Binet, plus any other tests Psychologist (who is half time) may choose, such as Bender.
4. Is IQ lower than 85 on Binet or WISC?
5. What is being asked here is: "Should the child still be considered for a transitional class (and therefore LD Resource Room services), even though his IQ is low on testing?"
6. PPVT is used as both a check on previous "intelligence" tests, and as a language test to aid in teaching.
7. Translated, this means is his MSSST score in the second lowest quartile or should the child be suspected of LD?
8. Transitional classes are provided for children after Kindergarten and 1st Grade, the limit is 25 children per class per school, children for LD Resource Room are selected from these classes.
9. Whether or not Mass Screening was initiated, a child can be referred anytime by Teachers, or Other Agent.

10. There is a private school for children with LD that refers children when they attend the regular schools, no specific official is indicated through whom referrals occur.
11. The Principals in this districts are call Director of School.
12. There is a limit of 20 imposed on the LD Resource Room Teacher.
13. Of course, the child's basic placement remains the Transitional Classroom.

Regular Class

Is child brought to Pre-kindergarten Registration?
PARENT

N

Y

PROJECT STAFF₁
schedules testing
date with
PARENT

N

Y

Is child brought to testing session?
PARENT

PROJECT VOLUNTEER
administers revised
MSSST

PARENT
completes
questionnaire
with
PROJECT VOLUNTEER

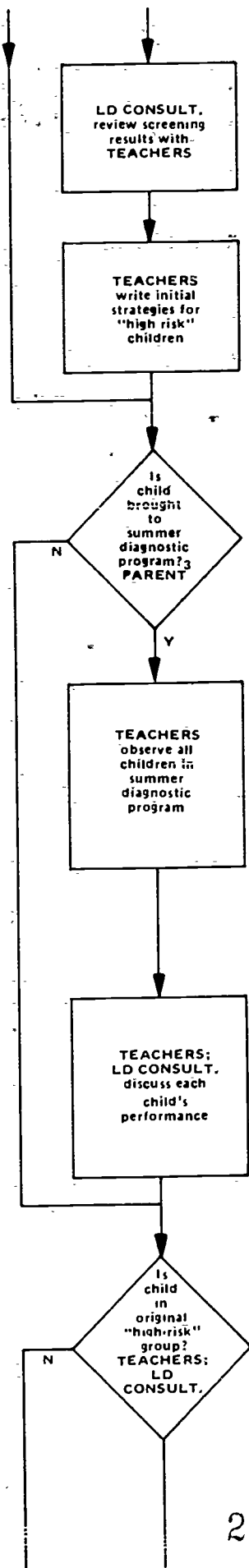
LD CONSULT₁
score tests
and reviews
Questionnaires

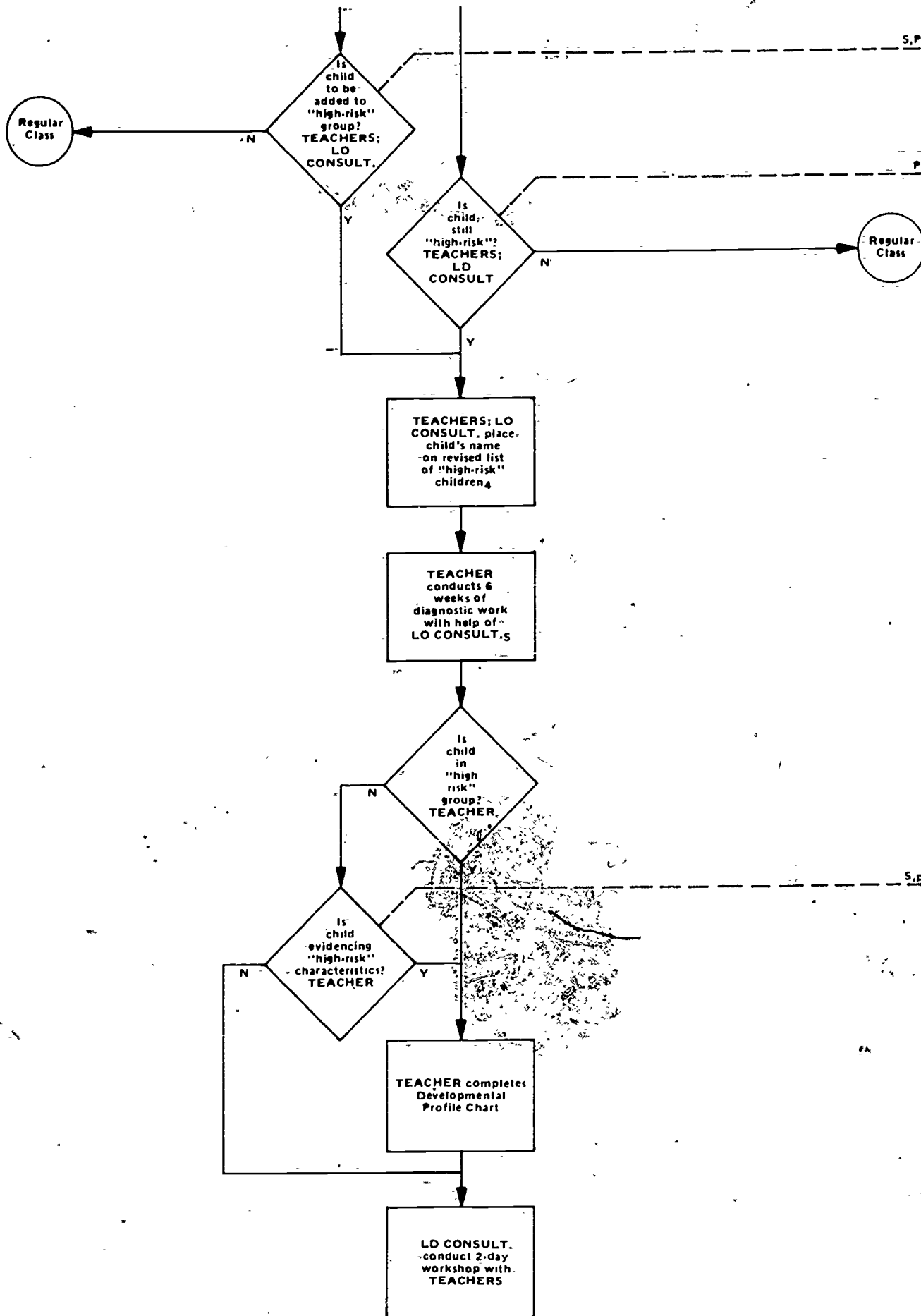
N

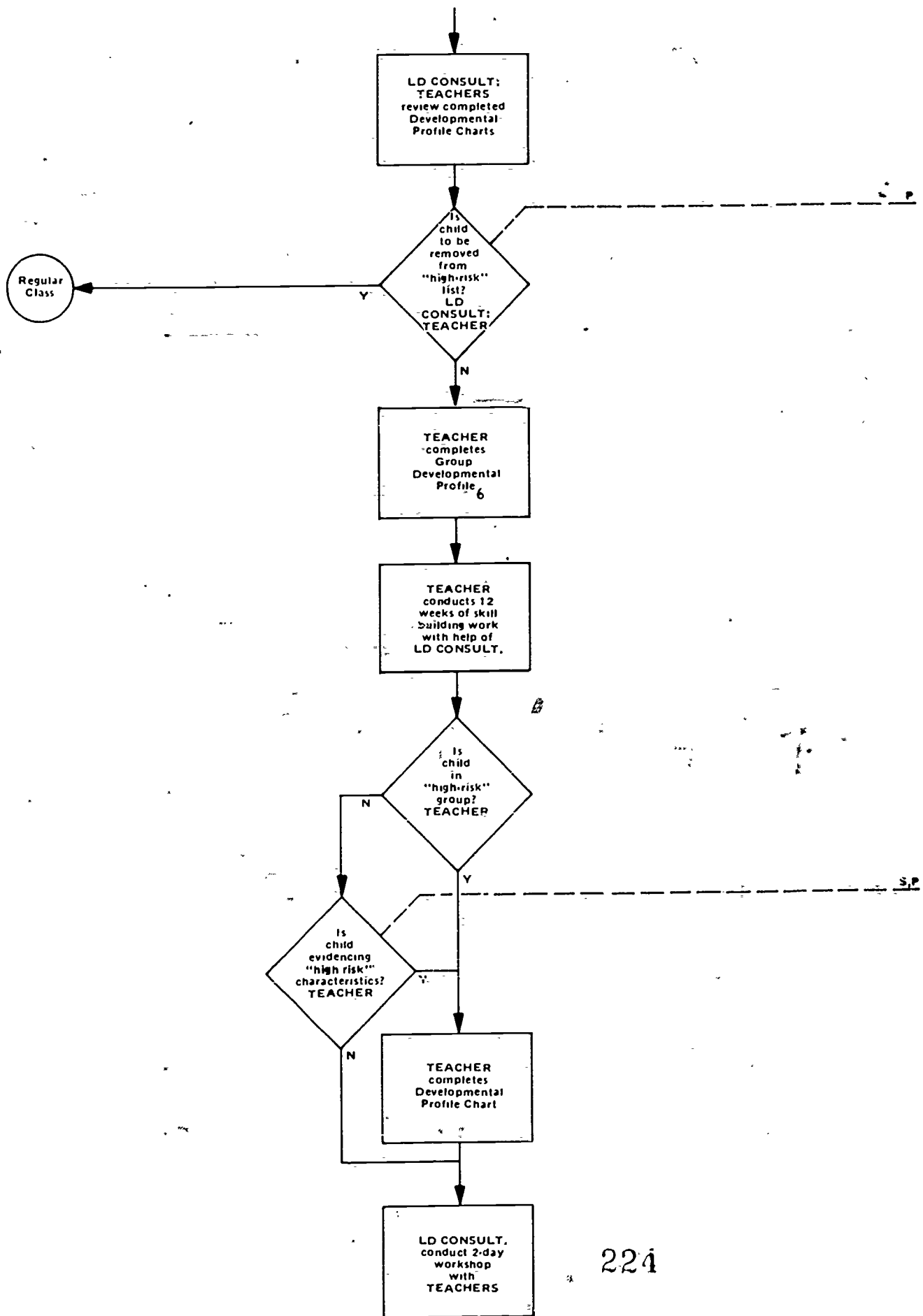
Y

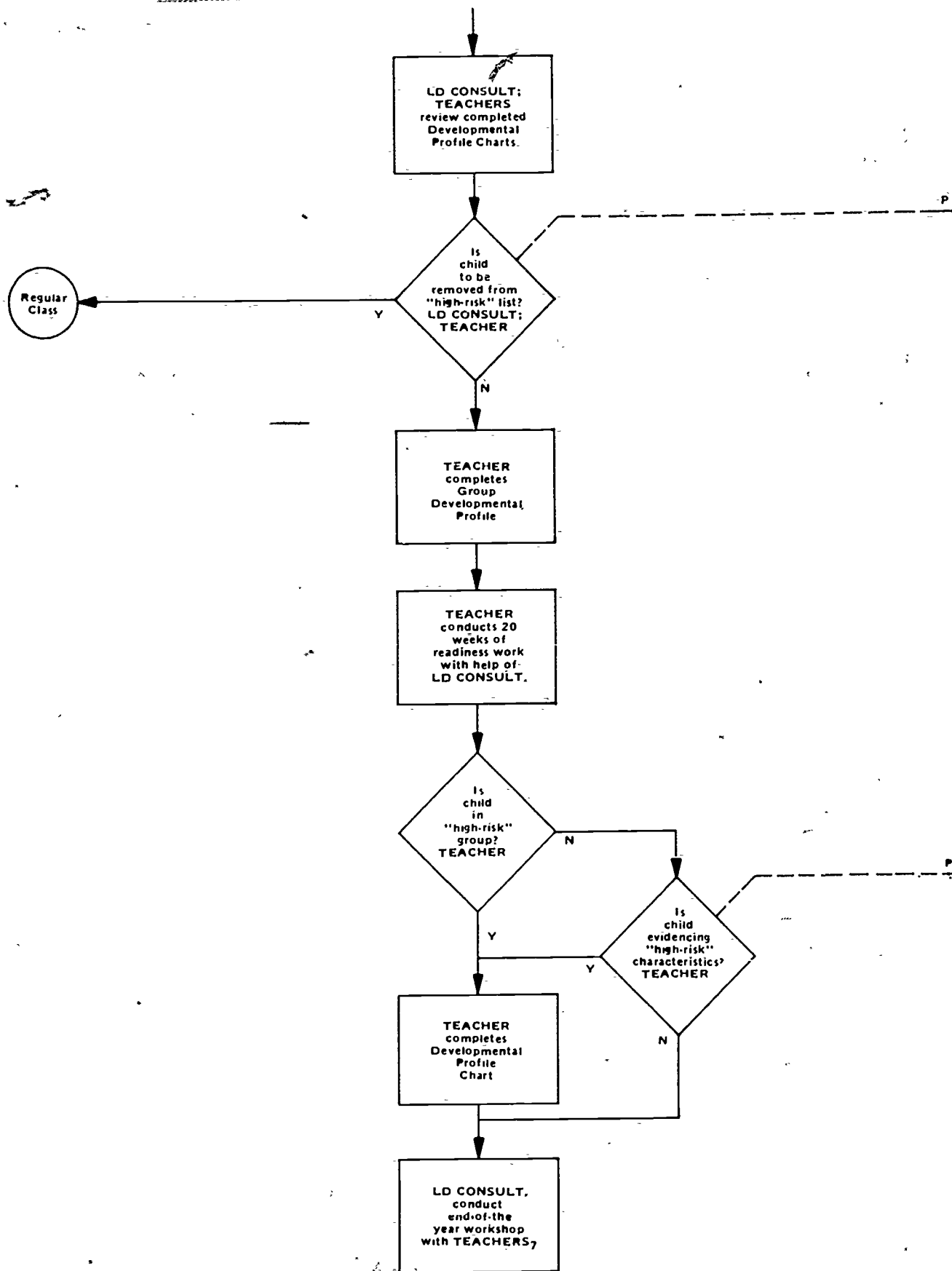
Is child suspected of LD?
("high risk")?
LD CONSULT.

S.D









I. GENERAL INFORMATION

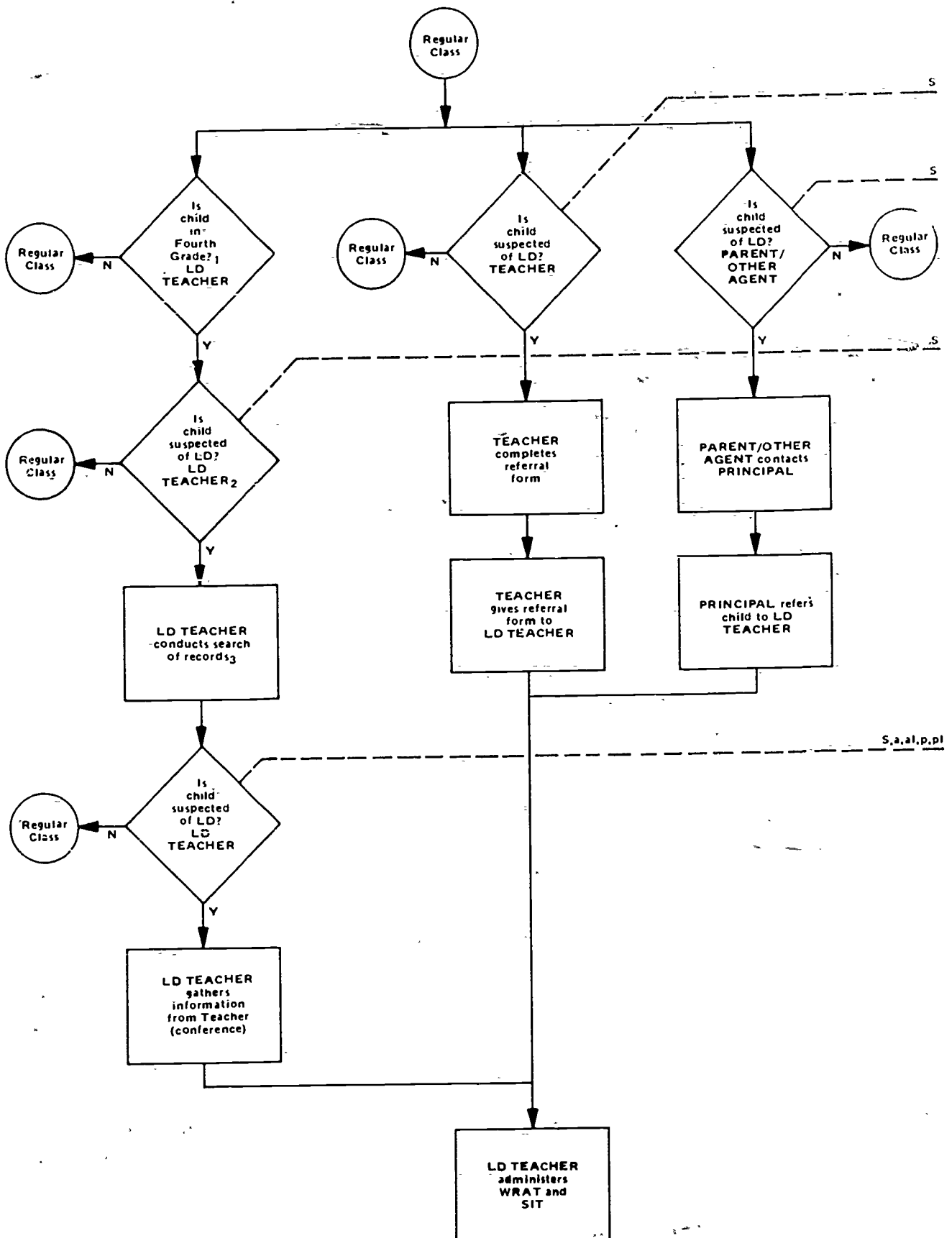
1. Project Code Letter: FF
2. Delivery System for Intervention: LD Consultative (Ages 3-5)
3. Initial Entry: Referral (Teacher)
Mass Screening (revised MSSST)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: LD Consultant
Teacher
 - b) Constraining decisions: Parent
Teacher
LD Consultant

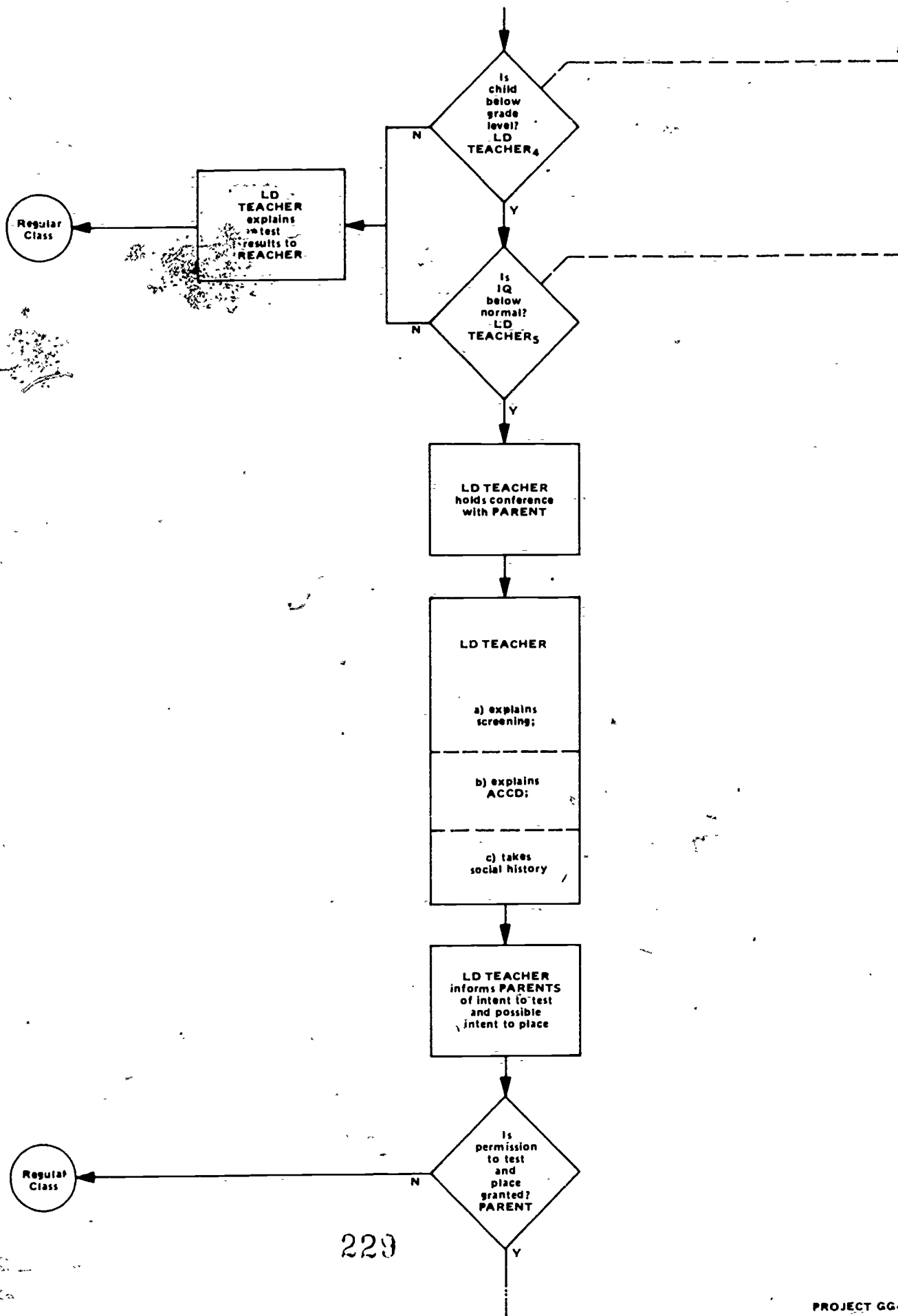
II. SPECIAL NOTATIONS

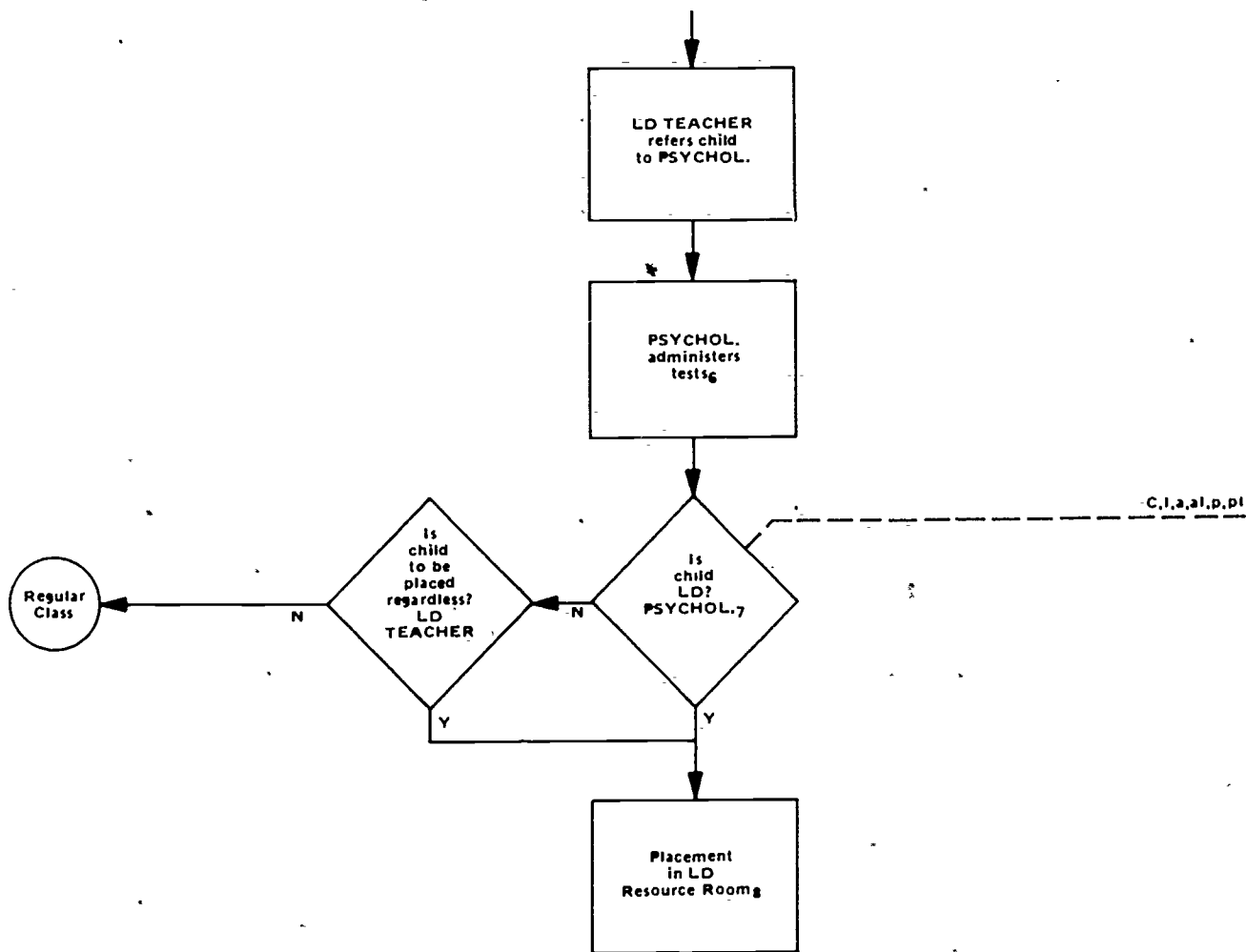
(footnotes apply to notations on flow-chart)

1. It is unclear exactly who makes this appointment, but most likely it is done by one of the volunteers trained by the project to administer the screening test. In addition to the volunteers, the Title VI-G Project staff includes an LD Coordinator, and several LD Consultants, each of whom has some special area of expertise. In general the staff is a support system for the LD Consultants in the schools and the teachers. The amount of support is diminished over time, through thorough training programs.
2. A child who falls below the cut-off point in the revised MSSST is classified as "high risk." Generally the cut-off is set at a raw score of 32, although communities are advised to adjust this if necessary to better reflect their population. Generally, this averages out to about the lowest 40% who are "high risk." The parent questionnaire is used only as supplemental data, and no child is included or excluded on the basis of this instrument.
3. The summer diagnostic session last for 2 days. On Day #1, the Teachers and LD Consultants review the screening data and write tentative prescriptions for the "high-risk" children. On Day #2, all children - "high-risk" and "non-high-risk" - spend one day in a simulated kindergarten, for the purposes of introducing the child to his class, orienting parents to the program, and allowing teachers to observe the children and modify (if necessary) their original decisions and strategies.
4. Factors that affect this revision include: parents report about child's condition at testing (e.g. sick); volunteers' comments about child test book; child's behavior and performance during summer diagnostic program. This group will be continuously revised during the year. As children appear to no longer need careful observation and extra work, they are removed from the "high-risk" group, and as new children appear to need extra help, they are added to the "high-risk" group.

5. During the entire year, a School Planning Team meets weekly to support the efforts of the LD Consultant and Teachers, to review all childrens' progress, and to consider alternative solutions to a particular child's problem. This Team consists of the LD Consultant, Teachers, Guidance Counselor and in some schools, the Principal.
6. The group profile combines all the ratings on the individual Developmental Profile Charts to provide a picture of the class learning patterns. This is used by the Teacher to group children and to establish priorities in the selection of content and methods of teaching.
7. At this workshop, the year's work is reviewed and plans are made for all children for the first grade with emphasis on those in the current "high-risk" group.







I. GENERAL INFORMATION

1. Project Code Letter: GG
2. Delivery System for Intervention: LD Resource Room (Grades 1-5)
3. Initial Entry: Referral (Teacher/Parent/Other Agent)
Mass Screening (Records Search)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher Other Agent
LD Teacher Psychologist
Parent
 - b) Constraining decisions: LD Teacher
Parent

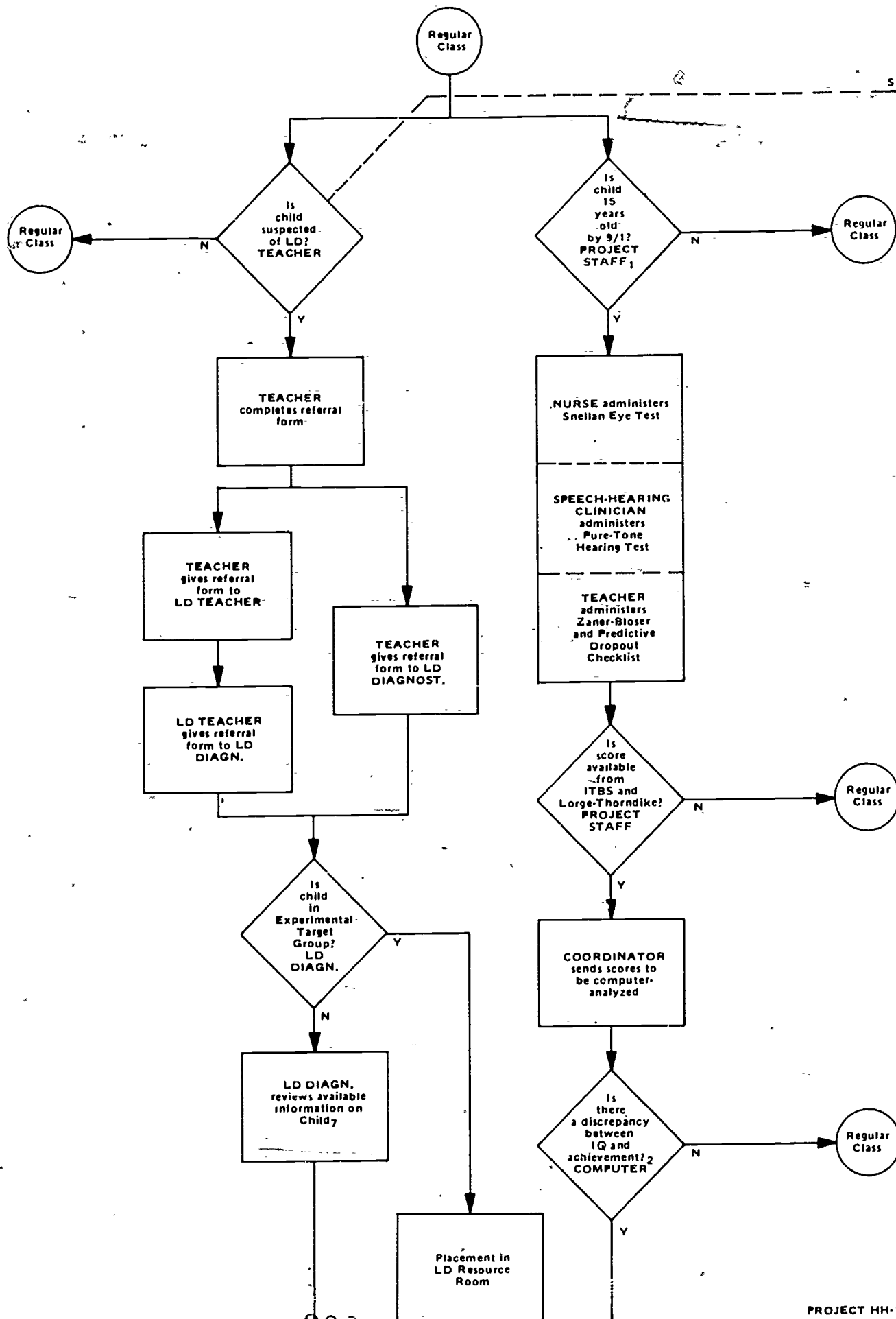
II. SPECIAL NOTATIONS

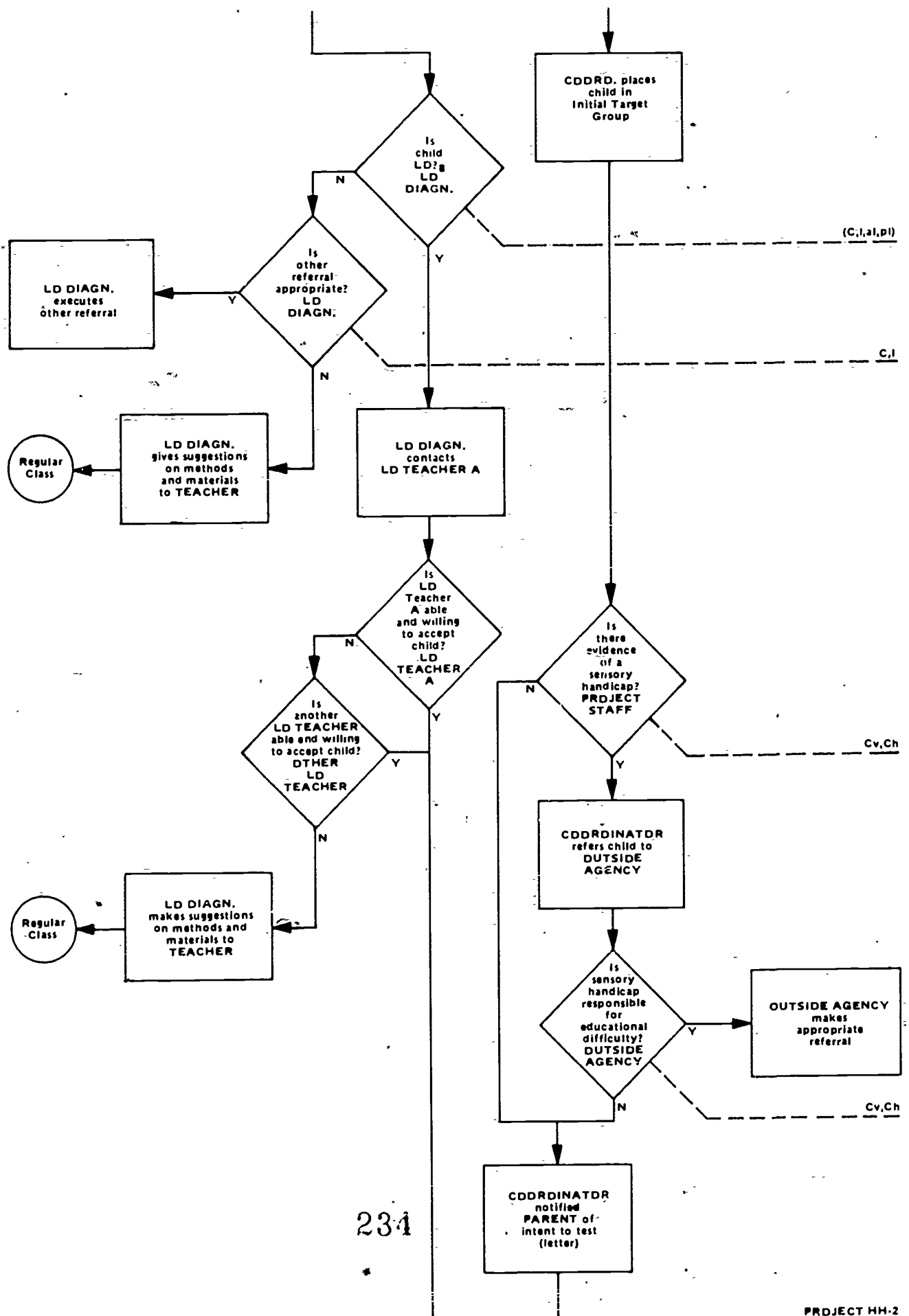
(footnotes apply to notations on flow-chart)

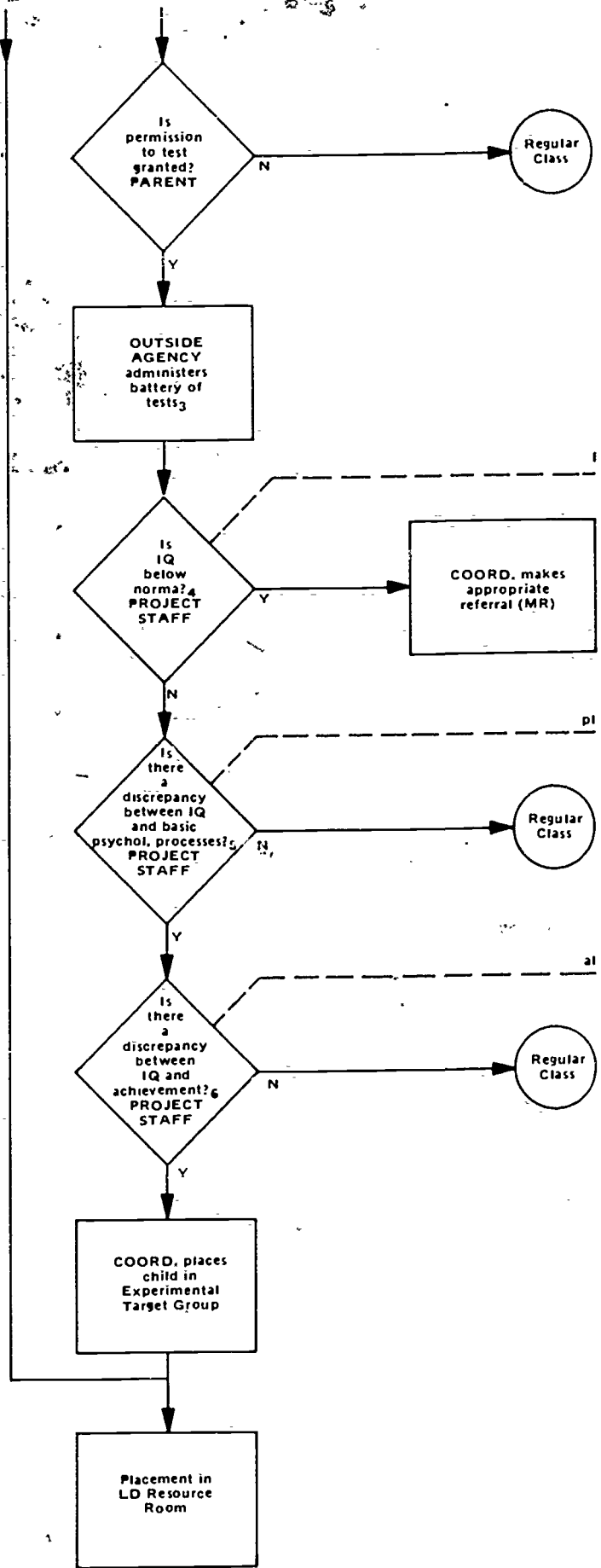
1. A "Records Search" approach is only used on fourth graders; however, any student, including fourth graders, may come through the other systems entries.
2. This is decided by talking to other teachers.
3. CTBS is always available as a State requirement; others might include: Metropolitan, IGE, Fountain Valley Diagnostic Tests.
4. For Kindergarten a 6-month deficit is considered low; for grades 1-4 the criterion is 1½ years down; for grades 5-6 it is 2 years down.
5. The IQ cut-off was 90, unless the quota for the resource room was unfilled; then LD Teacher could decide to take.
6. Tests include a) individual IQ test; b) achievement test, and c) 2 other non-specified tests (e.g. ITPA, Bender, Purdue, Detroit, Cooper-Smith Rating Form)
7. Exact decisions made by Psychologist are unknown; however, subsequent testing by LD Teacher used criteria:
 - a) discrepancies on IQ test,
 - b) average IQ (=90),
 - c) low performance (see footnote 4),
 - d) low IQ, plus "LD pattern" (i.e., achievement below grade and expectancy)
 - e) weakness in one or more process areas,
 - f) no other handicaps

Project GG-4

8. The LD Resource Room may be exclusively LD or it may include some EMH. After the placement is decided, a series of tests are given to aid in programming. Educational testing administered by the Resource Teacher includes: STanford (Reading or Math); Personality Questionnaire; School Attitude Survey; Optional others.







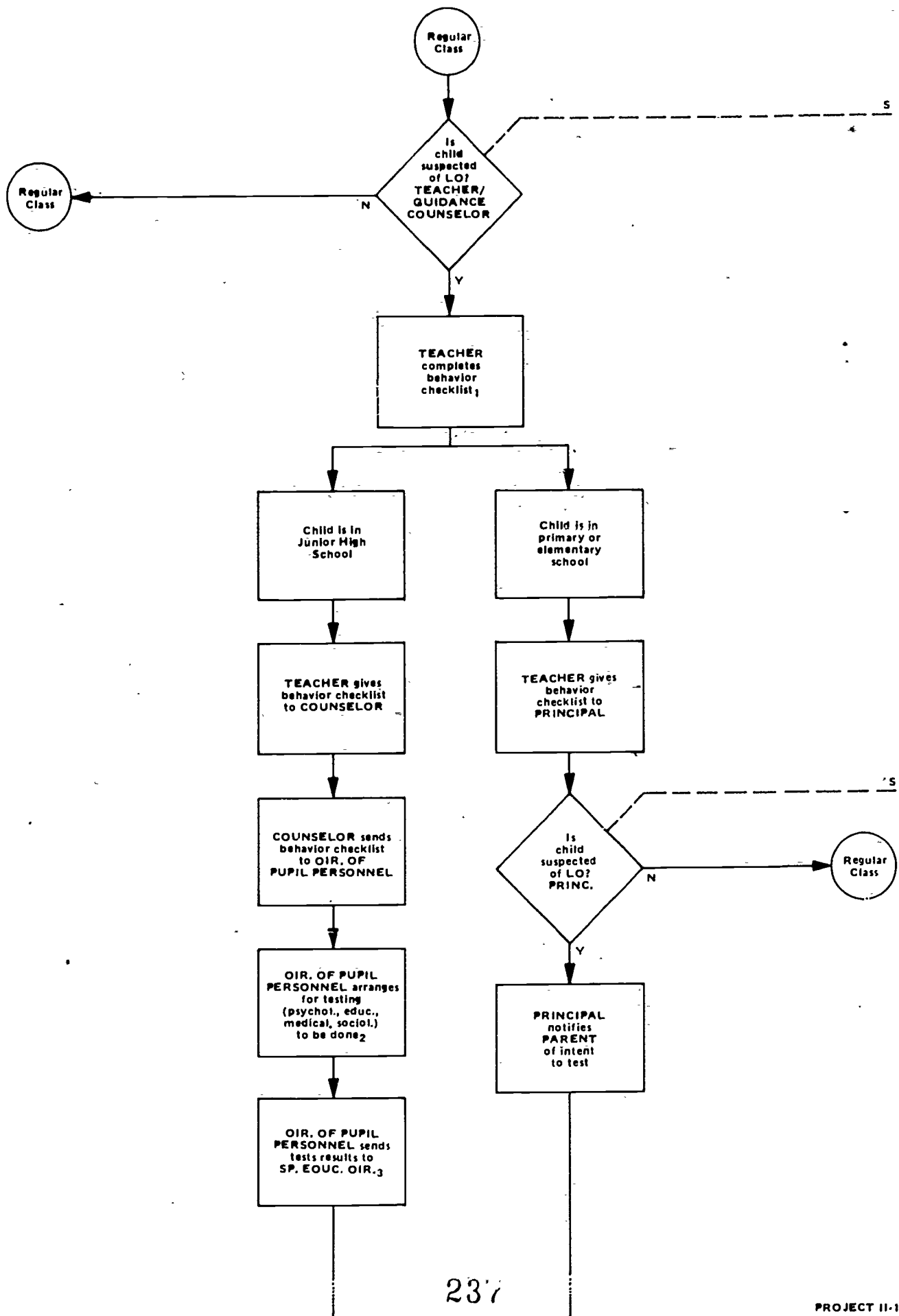
I. GENERAL INFORMATION

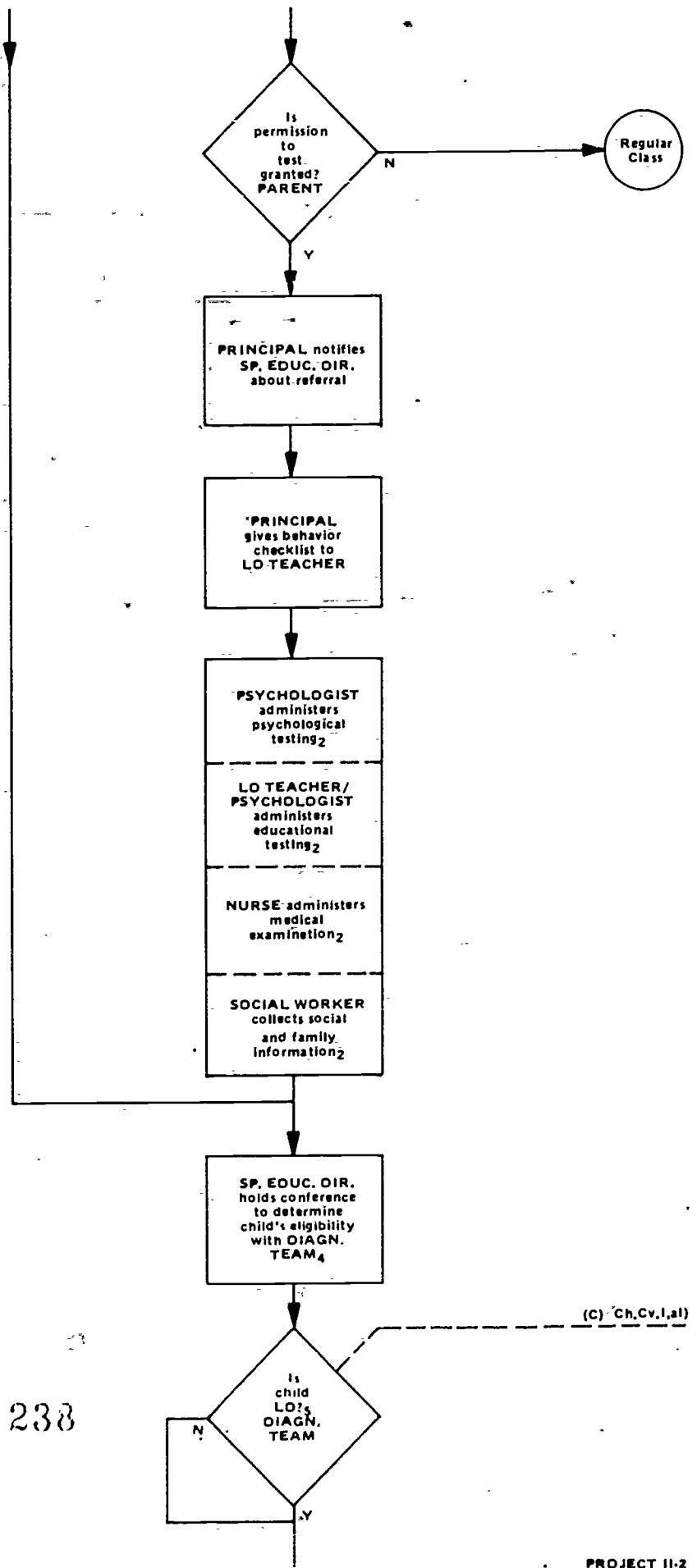
1. Project Code Letter: HH
2. Delivery System for Intervention: LD Resource Room (Grade 10)
3. Initial Entry: Referral (Teacher)
Mass Screening (ITBS; Lorge-Thorndike)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Computer Teacher
Project Staff LD Diagnostician
Outside Agency
 - b) Constraining decisions: Project Staff (Coordinator, LD Diagnostician,
LD Teachers, LD Consultants)
Parent
LD Diagnostician
LD Teacher

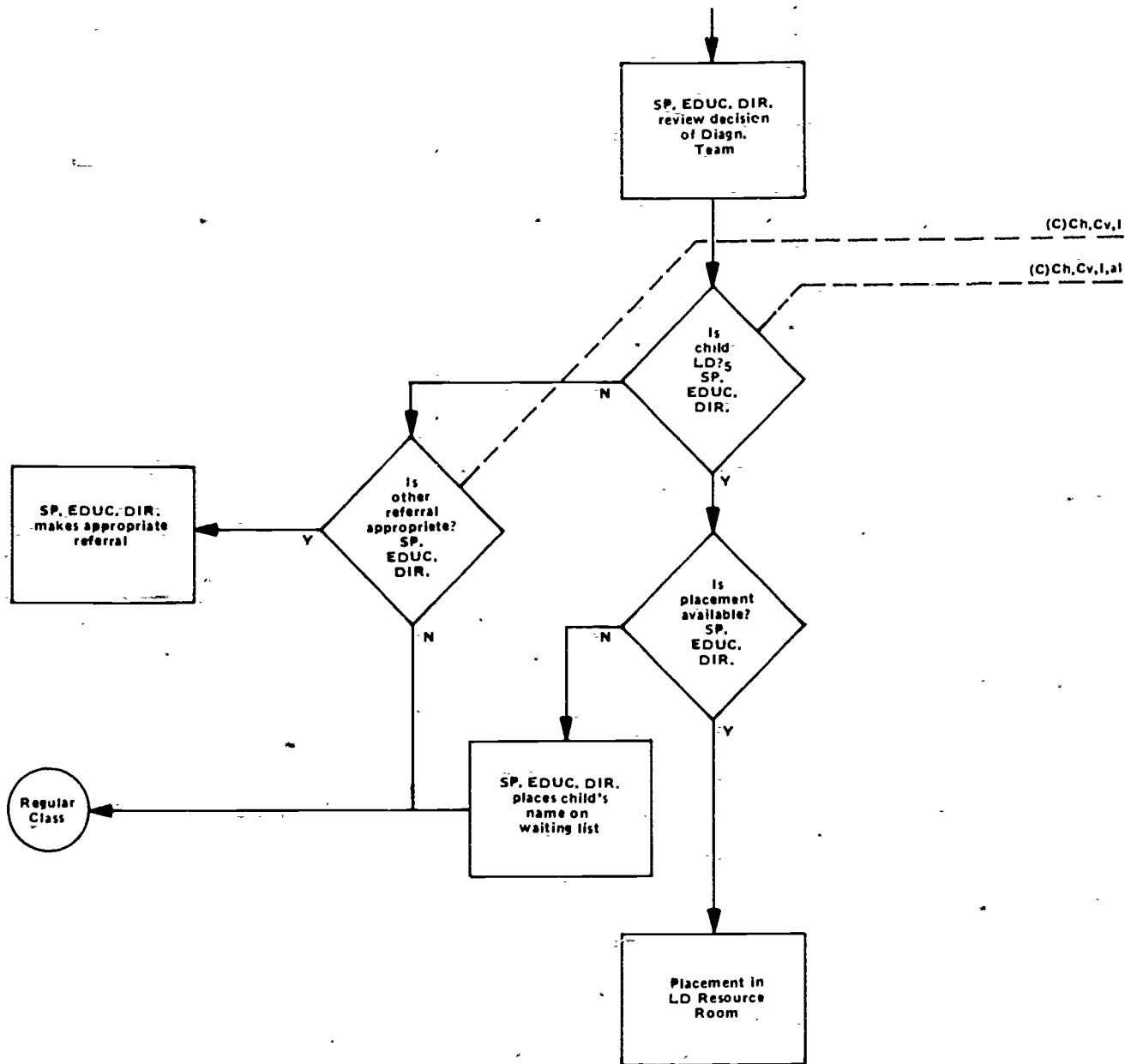
II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

1. Project Staff includes a Coordinator, and LD Diagnostician, several LD teachers (in addition to those in the school), several LD consultants. The term Project Staff is used whenever it is unclear which member(s) had responsibility for some activity or decisions. In this use, there were probably several staff persons who checked the records for the age information.
2. This is a strict statistical decision. The discrepancy must be 2 or more years, and must occur in 2 or more areas.
3. Battery included WISC, Detroit, Lincoln-Oseretsky, Stanford Reading, Standard Arithmetic.
4. "Below Normal" is defined as below 70 IQ.
5. The child must be below Mental Age by at least 2 years on at least 3 subtests of the Detroit.
6. The child must be below Mental Age by at least 2 years on either the Stanford reading or arithmetic achievement test.
7. This includes reviewing permanent records, talking to teachers, talking to student.
8. The criteria applied here are probably less exacting than in the mass screening process. The LD Diagnostician alone decides if the child meets the criteria, or if another referral is needed, or if the problem can be solved in the regular class.







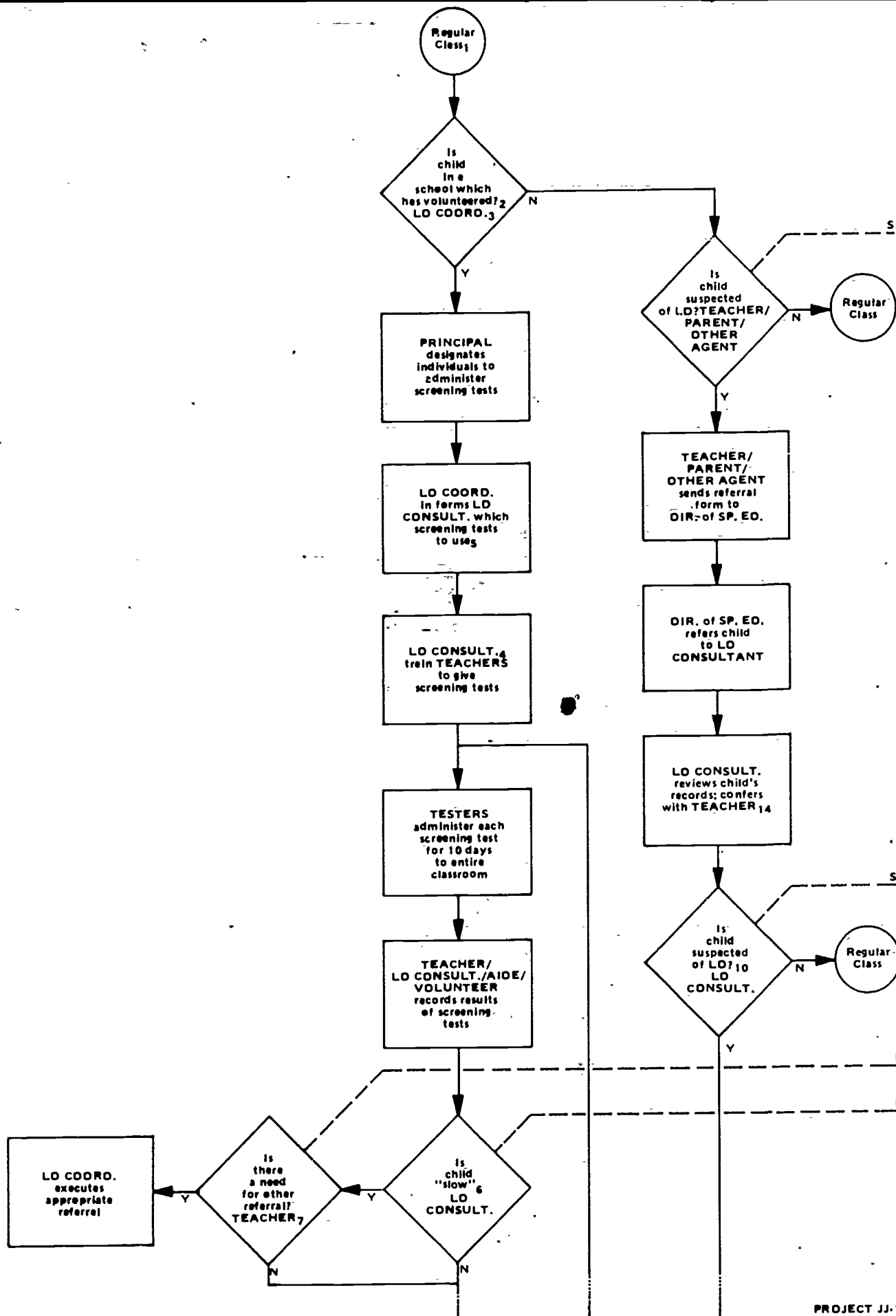
I. GENERAL INFORMATION

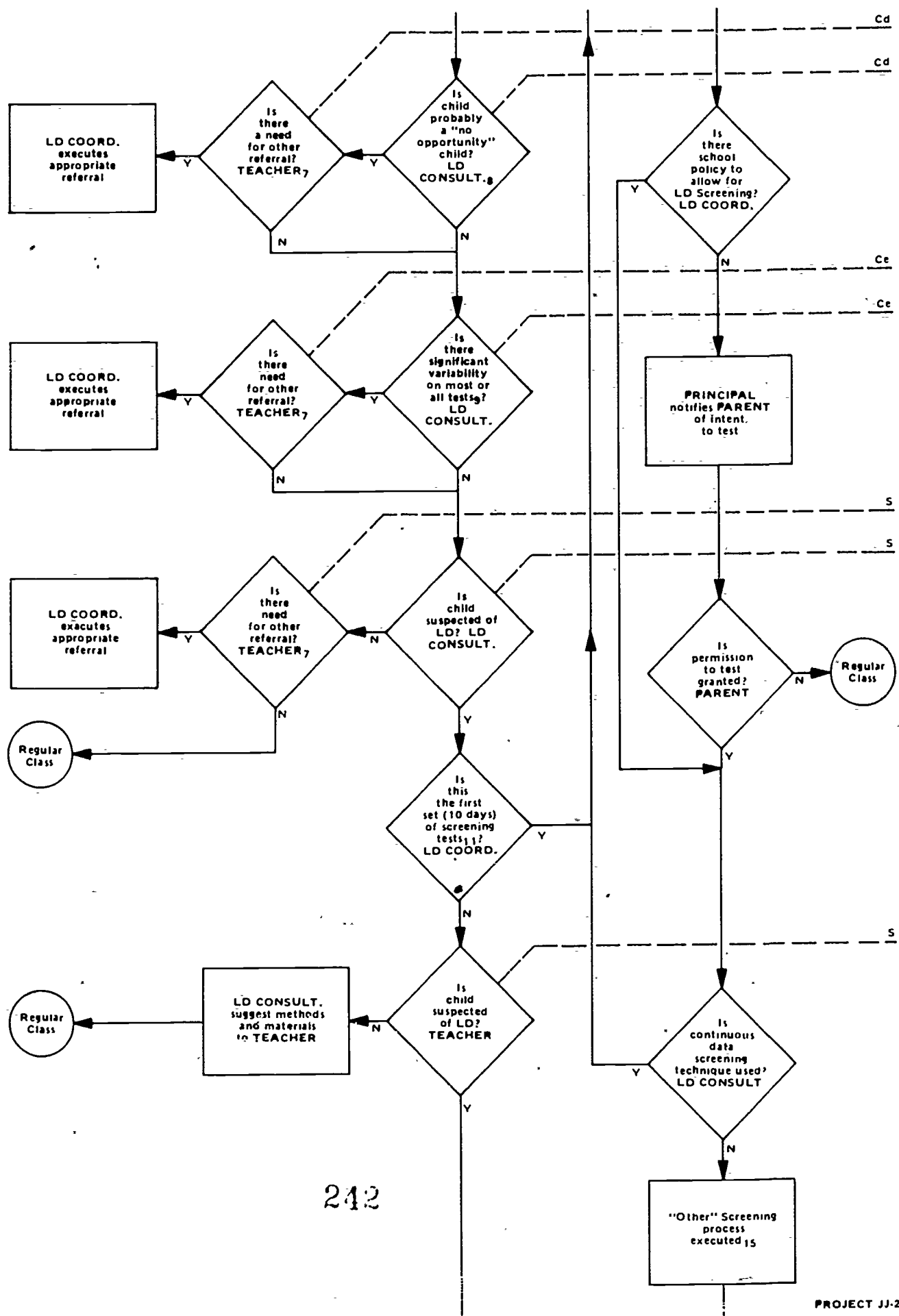
1. Project Code Word: II
2. Delivery System for Intervention: LD Resource Room (Grades 1-8)
3. Initial Entry: Referral (Teacher/Guidance Counselor)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
Guidance Counselor
Principal
Diagnostic Team (Director of Special Education,
Psychologist, social worker,
nurse, LD Teacher, referring teacher,
Principal)
 - b) Constraining decisions: Parent
Director of Special Education

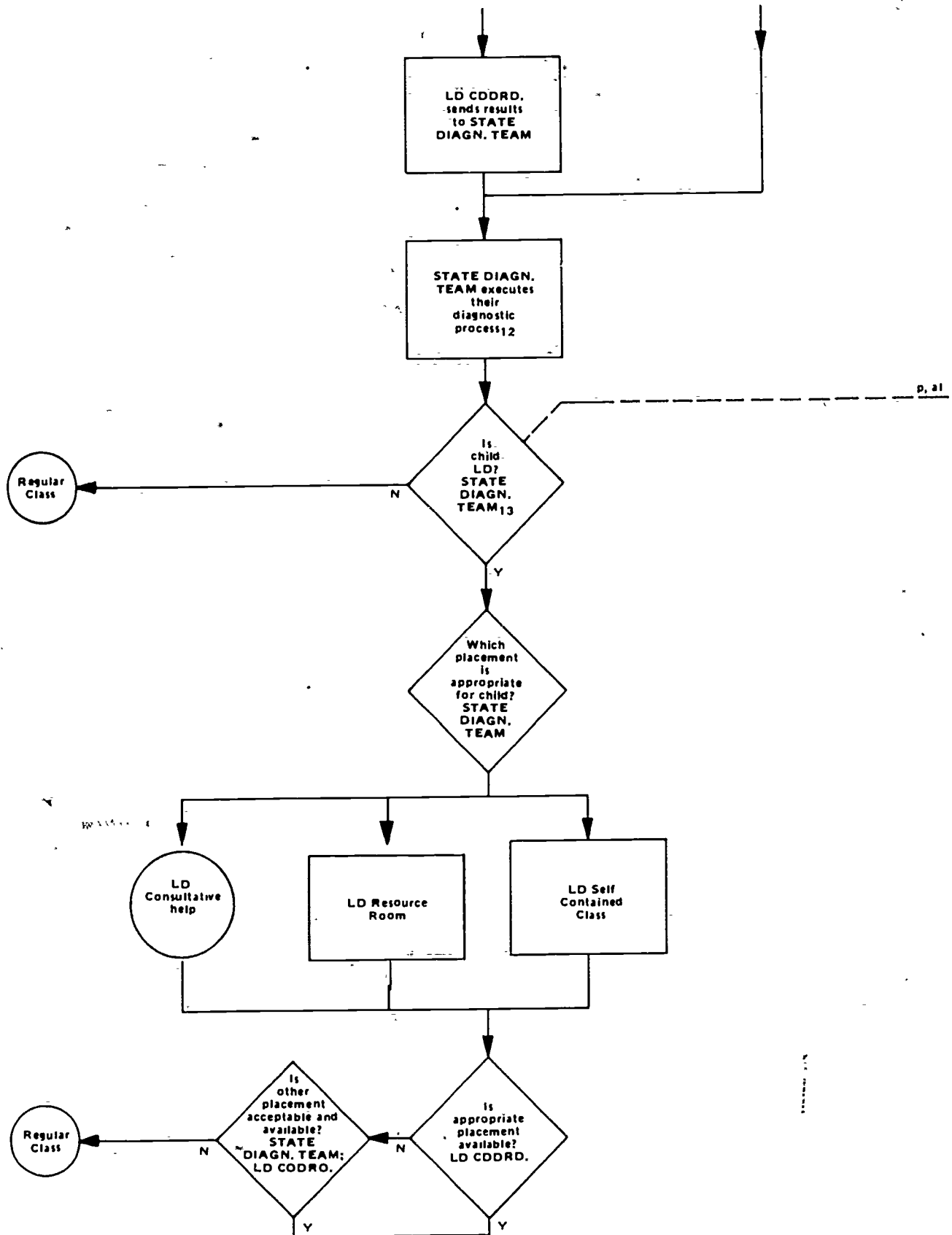
II. SPECIAL NOTATIONS

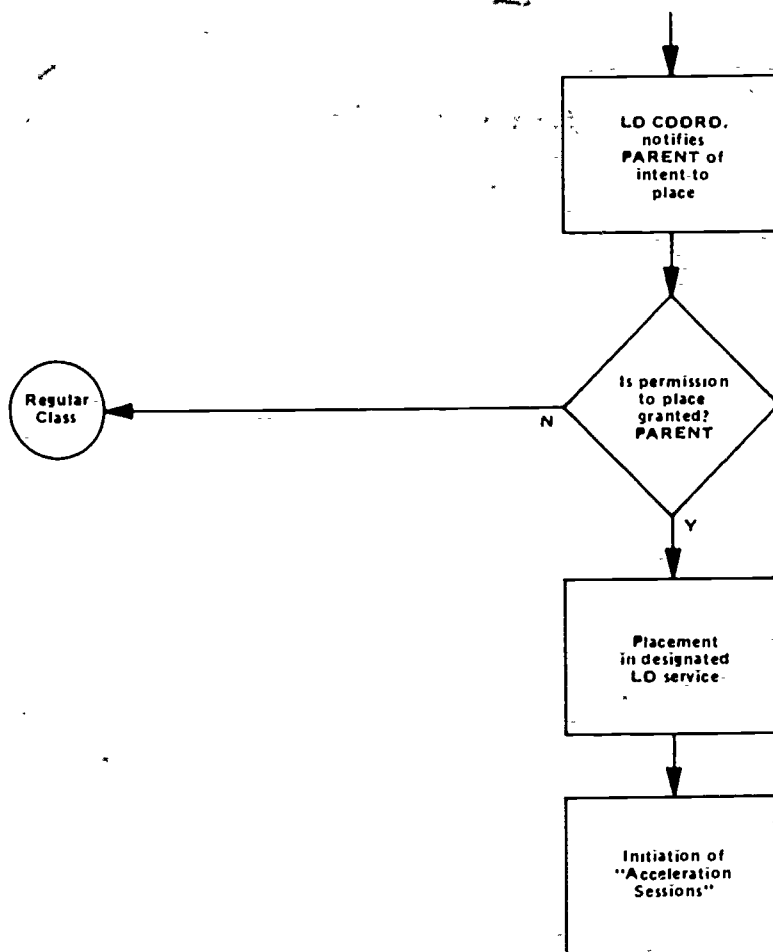
(footnotes refer to notations in flow-chart)

1. The Rubin, Simson & Betwee Behavior Checklist is recommended by the Title VI-G project, but some districts use their own, locally developed checklist.
2. The psychological testing includes the WISC, ITPA, and possibly other evaluations of mental abilities. Educational testing could include Slingerland, Frostig, Berry, PIAT, etc. (Engleman, PPVT, & Evanston Early Identification Scale were used for kindergarten). Medical exam includes vision and hearing tests. In addition, all children in special education are supposed to have a medical examination by their physician.
3. In districts without a specified Director of Special Education, the Superintendent will appoint someone else usually either the psychologist, the social worker, or the elementary supervisor.
4. Consists of Director of Special Education (or person so-named by superintendent), psychologist, social worker, nurse, LD teacher, principal, referring teacher, and possibly others involved with child.
5. Criteria for elimination were not discussed in the interview; however, state guidelines specify that there be no sensory handicap (as the primary problem), that IQ be 90 or above, and that there be a discrepancy between IQ and achievement.









I. GENERAL INFORMATION

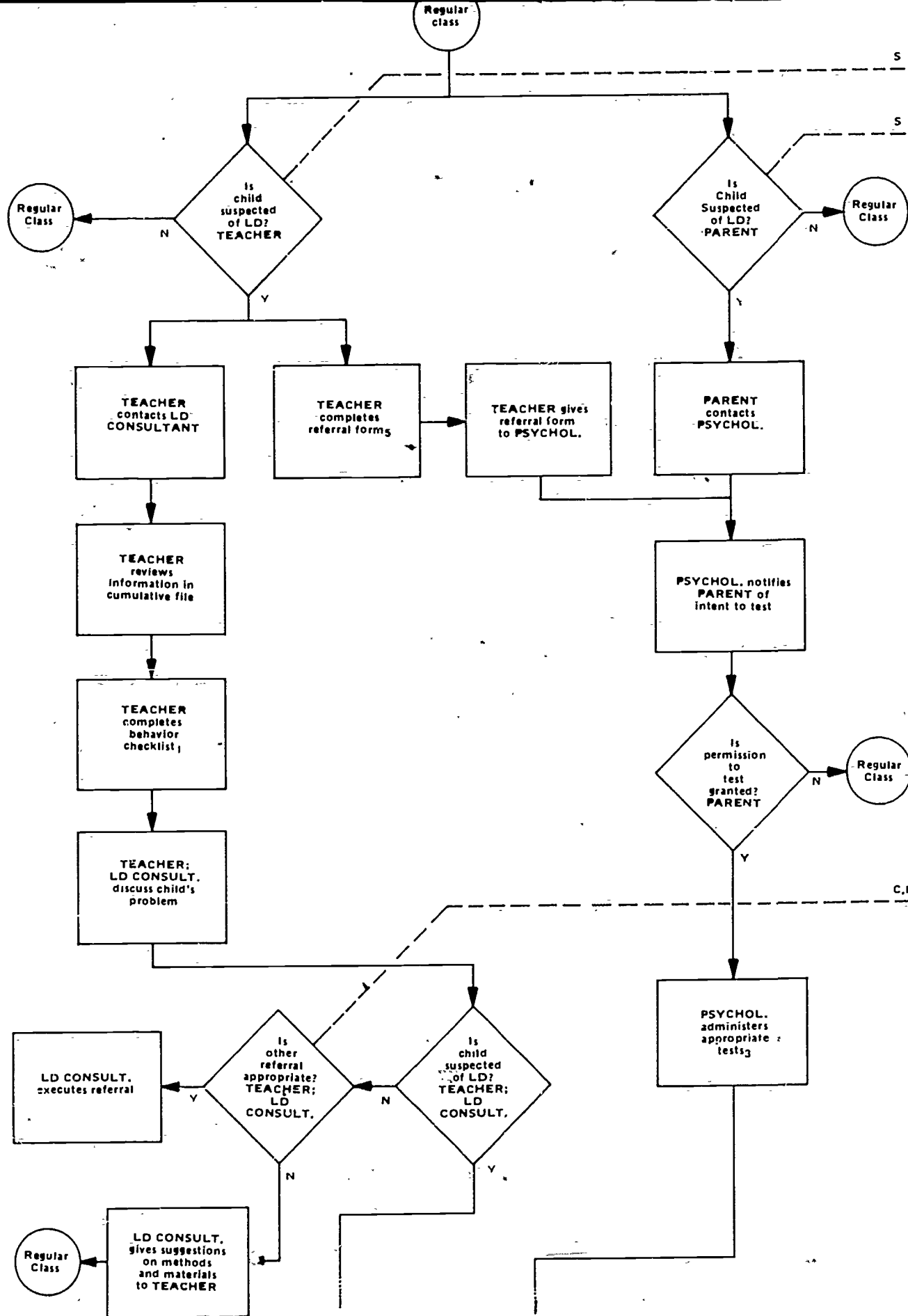
1. Project Code Letter: JJ
2. Delivery System for Intervention: LD Consultant (Grades K-3)
LD Resource Room
LD Self-Contained Class
3. Initial Entry: Mass Screening
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: LD Coordinator
LD Consultant
Teacher
State Diagnostic Team
 - b) Constraining decisions: LD Coordinator
State Diagnostic Team
Parent
LD Consultant

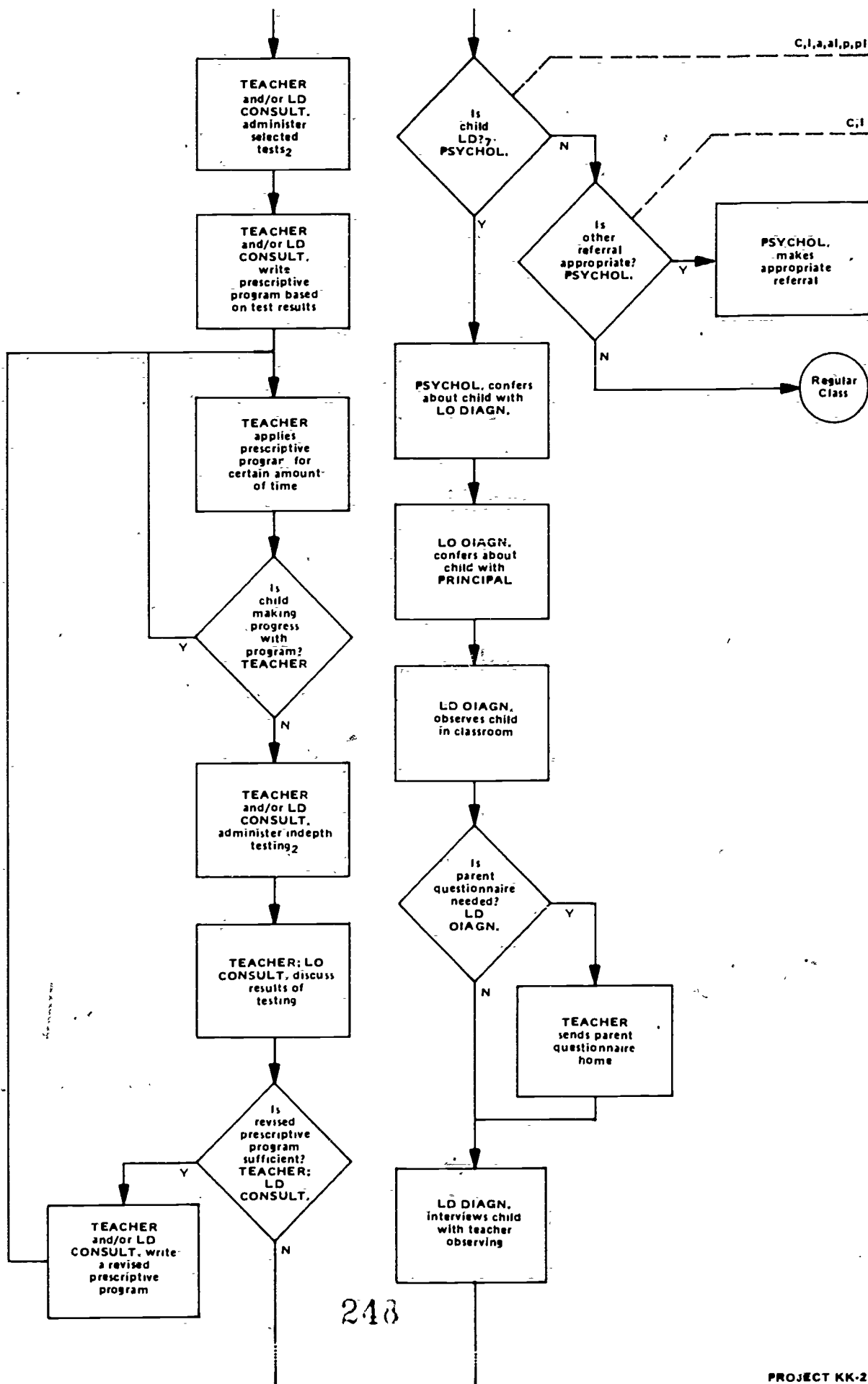
II. SPECIAL NOTATIONS

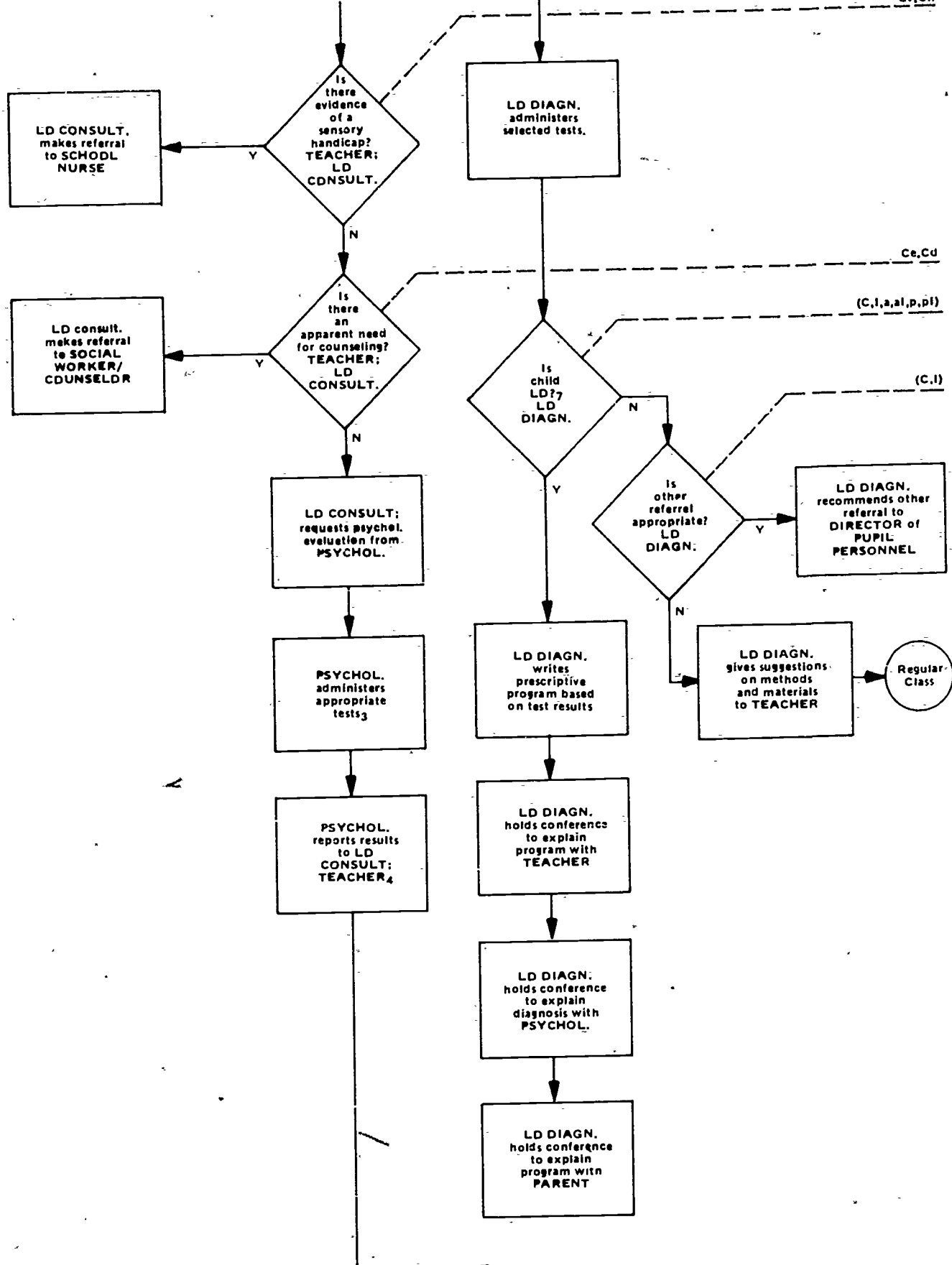
(footnotes apply to notations on flow-chart)

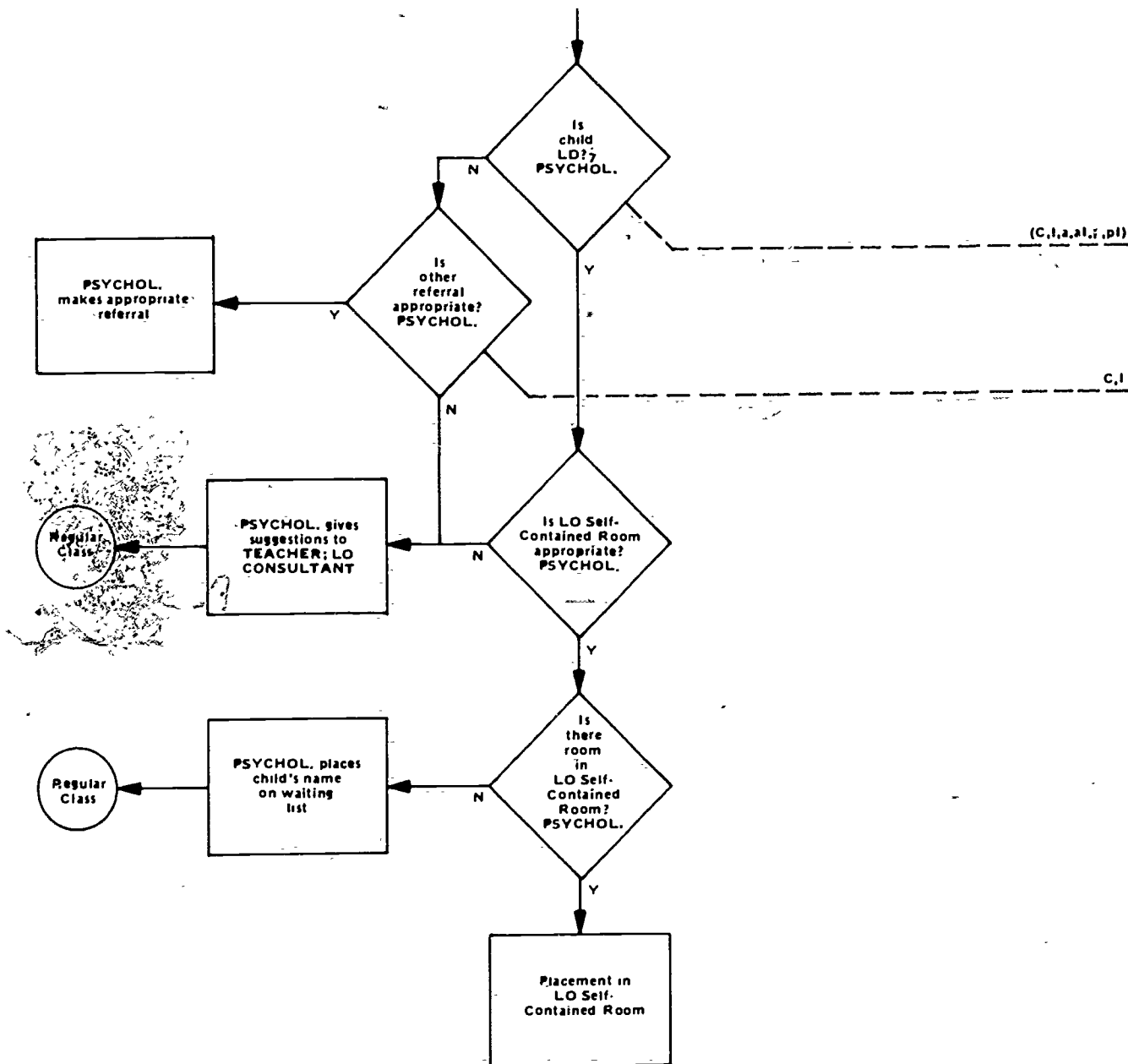
1. This flow-chart is an attempt to mesh a State-plan system and a specific Title VI-G system into one. Our apologies for any inconsistencies or misinterpretations that have resulted.
2. A Principal must permit mass screening to occur.
3. The LD Coordinator is the Title VI-G local project Director.
4. LD Consultant Staff consists of four LD Specialists; they not only train Teachers - they train parents and administrators to give the tests.
5. The screening tests are measurement of designated movement cycles (MC); the Coordinator determines which 2 or 3 MC to use at each grade level, depending on the results of testing from the previous year. Thus, there is decision-making in this event.
6. All decisions are based on values of performance (frequency) and growth (celeration). To qualify as "low" the child must be $\frac{1}{2}$ or more below the class median on 2 or 3 MC.
Child is considered "slow" and "low growth" if he has low performance (frequency) and low celeration.
7. Even though the cut-off criteria are established, the teacher must affirm further referral.

8. "No opportunity" is assumed on basis of Low Performance (frequency) - High Celeration on the 2 or 3 MC; there are two other possibilities:
 - a) high frequency - Low Celeration is considered as evidence that the task was too easy for the child.
 - b) high frequency - High Celeration is considered evidence that the child is proceeding satisfactorily.
9. Exact criteria for "variability" are not known; however, this circumstance is interpreted as indication of "disturbance", i.e., these children had behaviors that were disturbing to the teacher.
10. Suspicion of LD is based on pattern of High and Low Performance on 2 or 3 MC.
11. Final decisions are based on administering the 10 testing sessions twice (this is being reduced to 5 testing sessions twice).
12. No attempt is made here to detail that process.
13. Eligibility criteria are as follows:
 - (i) The child when tested individually achieves within near average, average or above average ranges of intellectual functioning.
 - (ii) The child shows a deficit in visual and/or auditory functioning including discrimination, memory and integration in visual and/or auditory functioning.
 - (iii) The child shows a reading performance significantly below that expected for his age, grade and intelligence level.
 - (iv) The child shows a spelling performance significantly below that expected for his age, grade and intelligence level.
 - (v) The child may show a significant deficit on visual-motor-development tests.
 - (vi) The child may show an arithmetic deficit significantly below that expected for his age, grade and intelligence level.
14. This may include having the teacher collect classroom data and discussing that.
15. The "other" screening process means whatever local system exists.









I. GENERAL INFORMATION

- i. Project Code Letter: KK
2. Delivery System for Intervention: LD Consultative (Grades K-12)
LD Self-Contained Room
3. Initial Entry: Referral (Teacher)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
LD Consultant
Psychologist
Parent
LD Diagnostician
 - b) Constraining decisions: Teacher
LD Consultant
Parent
LD Diagnostician

II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

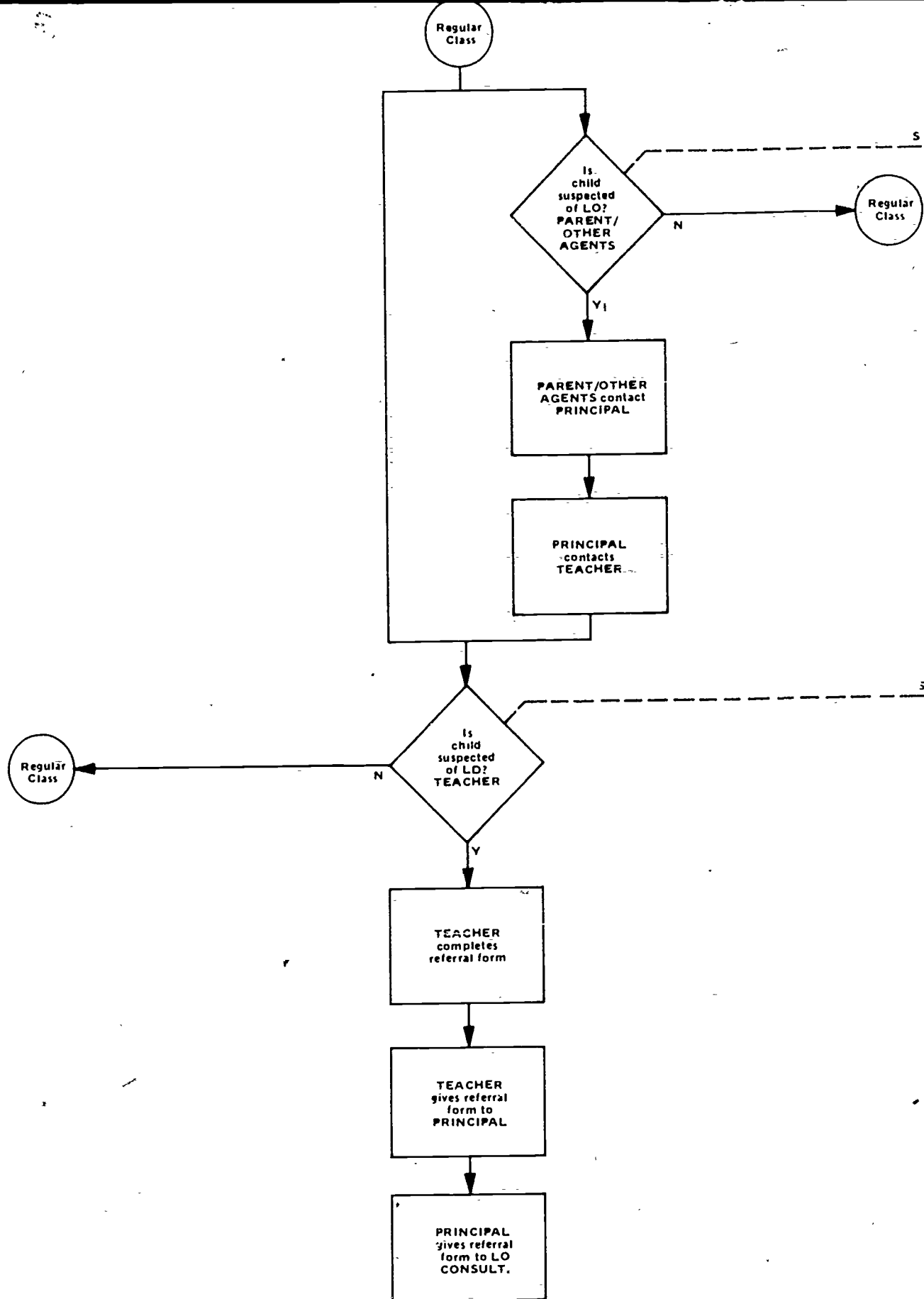
1. There are 2 available checklists, one a locally developed instrument, the other reproduced from Early Years (Spring 1971) and called "Learning Problems Checklist." The choice is left up to the particular LD Consultant with whom a teacher works.
2. Initially much of this testing is done by the LD Consultant, but the teacher will do more as she becomes more familiar with the instruments. There are initial demonstration-practice sessions, but even after that the Teacher and LD Consultant continue to work very closely.

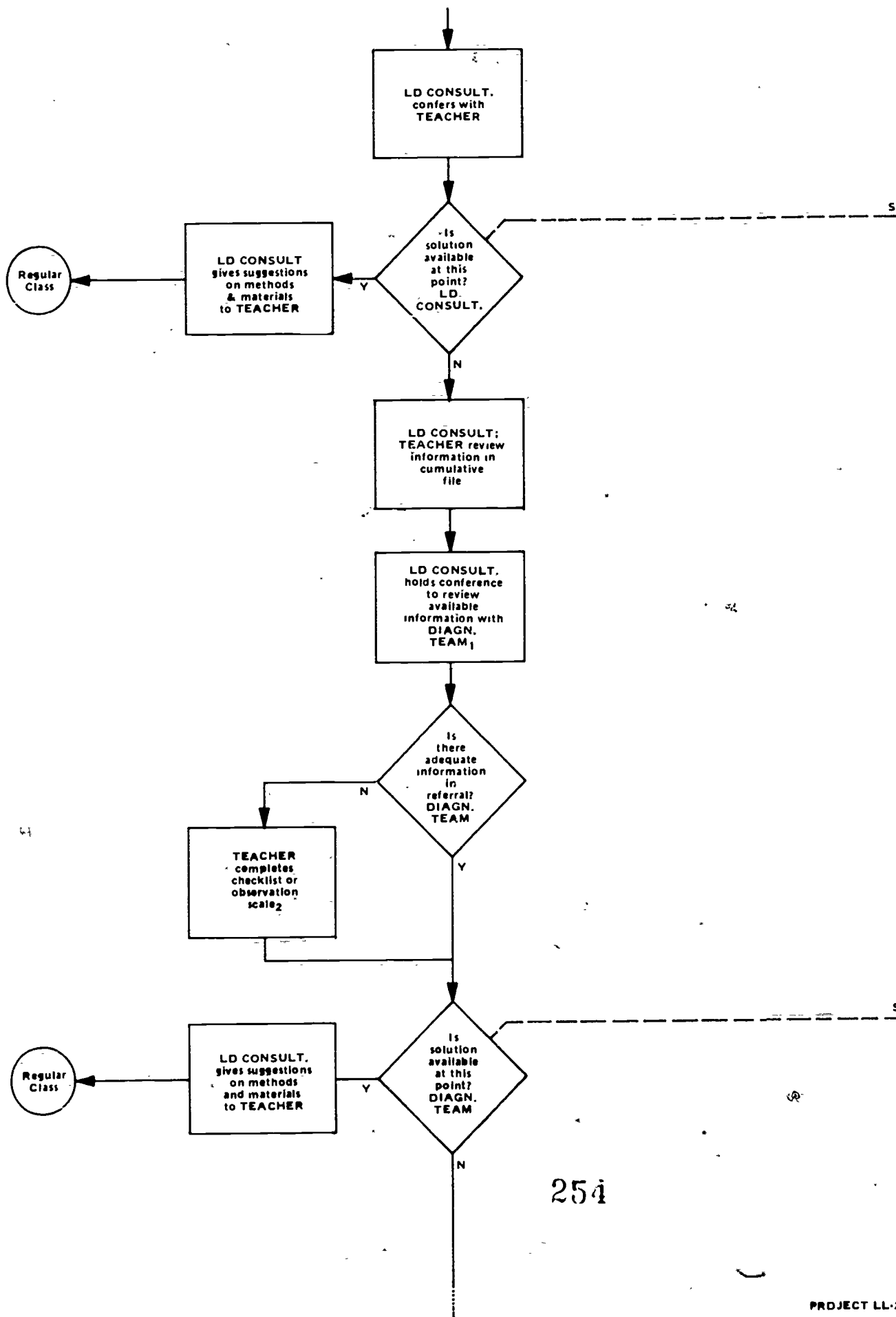
The Project has a list of acceptable tests, which are used both here and in the later in-depth testing (if that is needed). The LD Consultant (and later, the teacher) chose the tests that appear to be most appropriate:

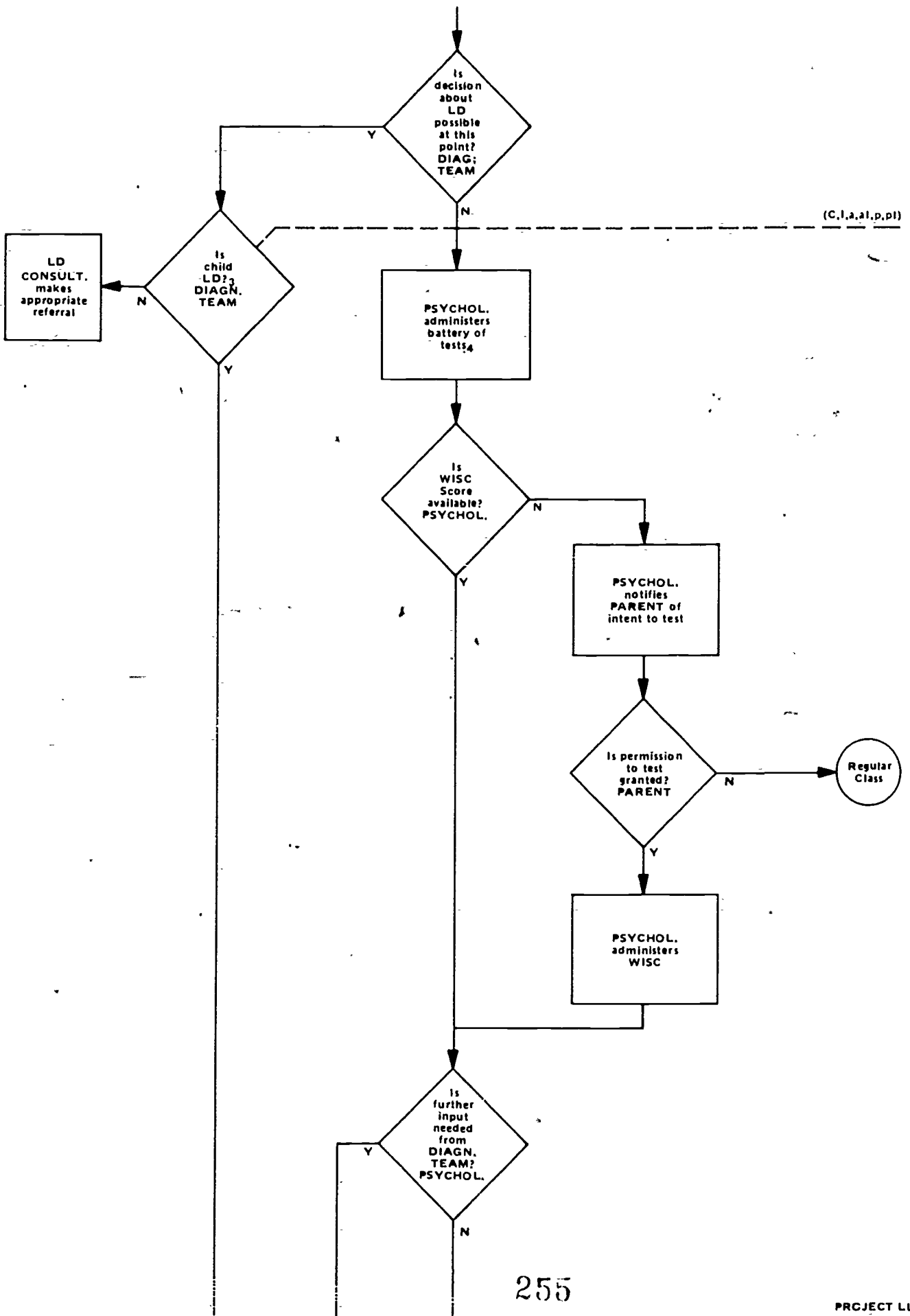
Gross Motor Skills Survey (locally developed)
Unity of Laterality Survey (adopted from Leavell Hand-Eye
Coordination Test (1958).
Slosson
VMI (Develop Test of Visual Motor Integration - Beery)
Wepman (Auditory Discrimination Test)
Frostig (Test of Visual Perception)
Informal Diagnostic Inventory (locally developed)
Slingerland (Slingerland Screening Tests for Children with Specific
Language Disability).
Botel Word Recognition Test
Botel Word Opposites Comprehension Test.

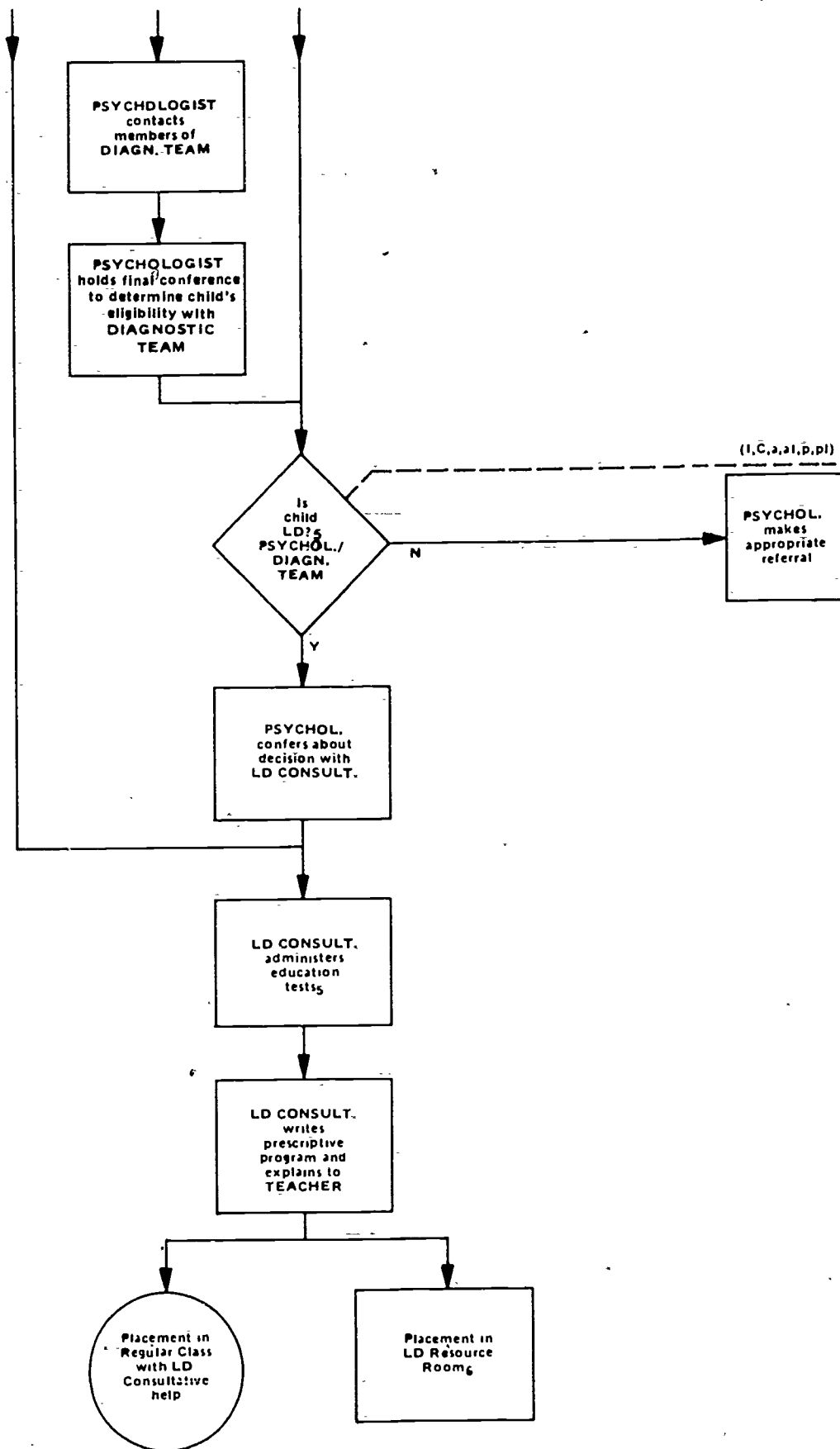
Word Discrimination Test (Huelsman Reading Inventory; Math Inventory
(criterion-referenced tests from University of Oregon)
Diagnostic Reading Aptitude and achievement tests (Monroe-Sherman)
Gray Oral Reading Test
Diagnostic Spelling Test (William Kortmeyer)
Diagnostic Test of Word Perception Skills (locally developed)
Alphabet Mastery Test (Merrill)
Roswell-Chall Auditory Blending Test
Key Math
PPVT
Motor-Free Visual Perception Test
Peabody Individual Achievement Test
ITPA (only test which cannot be administered by classroom teacher)

3. This would include WISC, since this is required for placement in LD Self-Contained Room. Other tests are not known.
4. The LD Consultant and teacher are not bound to accept the Psychologist's decision but they aren't likely to argue with a recommended placement if they've tried already to work with the child in the regular class. Of course, if the Psychologist evaluates the child as not eligible for special class placement, there is nothing that can be done unless they can change his mind.
5. Teachers who aren't familiar with the consultative services would normally just make a referral for testing to the psychologist. If after testing the child, s/he found evidence of an LD, the child would be referred to an LD Diagnostician. This person is part of the Title VI-G Project, but functions in a slightly different capacity from the LD Consultants, in order to take care of the "over-flow" students coming from the psychological services division.
6. There is no information regarding the criteria used here.
7. All inclusion decisions are listed, since we are unsure of the true process.









I. GENERAL INFORMATION

1. Project Code Letter: LL
2. Delivery System for Intervention: LD Consultative (Grades K-6)
LD Resource Room
3. Initial Entry: Referral (Teacher/Parent/Other Agent)
4. Personnel Involved in Decision-Making:
 - a) Eligibility decisions: Teacher
parent/other Agents
LD Consultant
Diagnostic Team
Psychologist
 - b) Constraining decisions: Diagnostic Team (LD Consultant, Principal,
Psychologist, Speech Therapist,
Teacher)
Psychologist

II. SPECIAL NOTATIONS

(footnotes apply to notations on flow-chart)

1. Diagnostic Team includes LD Consultant, Principal (who is the nominal head), Psychologist, Speech Therapist, Teacher. Their basic function is to decide whether testing is needed to make a decision. In one case the LD Consultant is most influential; in another case, the Psychologist is.
2. The instrument used is up to the teacher.
3. At this point, the criteria for determining that an LD exists is unclear. It must be assumed, therefore, that all the inclusion and exclusion questions are asked.
4. Includes ITPA, Bender, Wepman, WRAT, and WISC. (unless it has been given).
5. Specific tests are not designated. The purpose of this testing, however, is to pin-point deficit areas for the prescription-writing.
6. Since this project is in a rural area, only a few schools will have LD Resource Rooms, but where available they will be used. The majority of prescriptive programs are carried out in Regular Class.

Project LL-5